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ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature – Second Regular Session

COMMITTEE ON HEALTH

Report of Regular Meeting
Tuesday, February 16, 2016
House Hearing Room 4 -- 2:00 p.m.

Convened 4:33 p.m.
Recessed
Reconvened
Adjourned 8:50 p.m.

Members Present
Mr. Boyer
Mr. Friese
Mr. Lawrence
Mr. Meyer
Mrs. Cobb, Vice-Chairman
Mrs. Carter, Chairman

Members Absent

Agenda
Original Agenda – Attachment 1

Request to Speak
Report – Attachment 2

Presentations

Name	**Organization**	**Attachments** (Handouts)
Will Humble	Division Director for Health Policy and Evaluation, UA Center for Population Science and Discovery	3

Committee Action

Bill	**Action**	**Vote**	**Attachments** (Summaries, Amendments, Attendance)
HB2307	DPA	6-0-0-0	4, 5, 6
HB2501	DPA	4-2-0-0	7, 8, 9
HB2312	DP	6-0-0-0	10, 11, 12
HB2640	DPA	6-0-0-0	13, 14, 15
HB2061	DPA/SE	6-0-0-0	16, 17, 18, 19
HB2361	DPA/SE	6-0-0-0	20, 21, 22, 23
HB2667	DP	6-0-0-0	24, 25
HCR 2039	DP	6-0-0-0	26, 27
	COMMITTEE ATTENDANCE		28

Sandy Kelley, Chairman Assistant
Wednesday, February 17, 2016

(Original attachments on file in the Office of the Chief Clerk; video archives available at http://www.azleg.gov)

Convened: 4:33 pm
adjourned: 8:50 pm

REVISED #2 - 02/12/16 **REVISED #2 - 02/12/16** **REVISED #2 - 02/12/16**

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

REGULAR MEETING AGENDA

COMMITTEE ON HEALTH

DATE Tuesday, February 16, 2016 ROOM HHR 4 TIME 2:00 P.M.

Members:

Mr. Boyer	Mr. Lawrence	Mrs. Cobb, Vice-Chairman
Mr. Friese	Mr. Meyer	Mrs. Carter, Chairman

Presentation
Trends in Emergency Department Use for Dental Problems Among Medicaid Members in Arizona
- Will Humble, Division Director for Health Policy and Evaluation, UA Center for Population Science and Discovery

Bills	Short Title	Strike Everything Title
*HB2061 S/E dpa	medical marijuana; pregnancy exclusion (Townsend, Finchem: Allen J, et al)	**S/E: medical marijuana; pregnancy; signage**
6-0-0-0	HEALTH held 0-0-0-0-0, RULES	
HB2312 dp	advisory council; Indian health care. (Hale, Benally, Saldate, et al)	
6-0-0-0	HEALTH, RULES	
HB2501 dpa	health regulatory boards; transfer; DHS (Carter)	
4-2-0-0	HEALTH	
HB2640 dpa	appropriation; pediatric neurological autoimmune disorders (Carter: Friese, Lawrence, et al)	
6-0-0-0	HEALTH, APPROP, RULES	
HB2667 dp	dental care; treatment; volunteer care (Cobb)	
6-0-0-0	HEALTH, RULES	

Attachment 1

Bills	Short Title	Strike Everything Title
HCR2039 dp	multiple sclerosis awareness week	
	(Brophy McGee, Carter: Allen J, et al)	
6-0-0-0	HEALTH, RULES	

ADDENDUM #1 - 02/11/16

HB2307 dpa	anatomical gifts; procurement organizations; licensure	
	(Cobb, Borrelli: Shope)	
6-0-0-0	HEALTH, RULES	

ADDENDUM #2 - 02/12/16

HB2361 S/E dpa	technical correction; state land; sale	**S/E: diabetes management; child care facilities**
	(Carter)	
6-0-0-0	HEALTH, RULES	

* On previous agenda

ORDER OF BILLS TO BE SET BY THE CHAIRMAN

~~JY~~
slk
~~2/11/16~~
2/12/16

People with disabilities may request reasonable accommodations such as interpreters, alternative formats, or assistance with physical accessibility. If you require accommodations, please contact the Chief Clerk's Office at (602) 926-3032, TDD (602) 926-3241.

Information Registered on the Request to Speak System

House Health (2/16/2016)

HB2061, medical marijuana; pregnancy exclusion

Testified in support:

Jessie Armendt, MARCH OF DIMES BIRTH DEFECTS FOUNDATION; Kristen Boilini, Arizona Section Of The American College Of Ob/Gybs

Testified as neutral:

Shannon Whiteaker, AZ DEPT OF HEALTH SERVICES

Support:

Jessica Rainbow, AZ-AMERICAN CONGRESS OF OBSTETRICIANS & GYNECOLOGISTS; Emily Jenkins, Arizona Council Of Human Service Providers

Neutral:

Susan Cannata, Arizona Chapter Of The American Academy Of Pediatrics, The Arizona Academy Of Family Physicians; Leonard Clark Clark, representing self

Oppose:

Dianne Post, representing self

All Comments:

Jessica Rainbow, AZ-AMERICAN CONGRESS OF OBSTETRICIANS & GYNECOLOGISTS: ACOG Arizona Section supports the Boyer strike everything amedment; Susan Cannata, Arizona Chapter Of The American Academy Of Pediatrics, The Arizona Academy Of Family Physicians: could support a signage bill limited to language on harms to the fetus; do not support language on reporting to DCS

HB2312, advisory council; Indian health care.

Testified in support:

Alida Quiroz-Montiel, representing self

Support:

Kevin Earle, Executive Director, Arizona Dental Association; Theresa Ulmer, COCOPAH INDIAN TRIBE; Kim Russell, representing self; Ben Alteneder, AZ EARLY CHILDHOOD DEVELOPMENT & HEALTH BOARD; Norris Nordvold, INTER TRIBAL COUNCIL OF ARIZONA

Neutral:

Christopher Vinyard, AZ HEALTH CARE COST CONTAINMENT SYSTEM

Attachment 2

All Comments:

Kevin Earle, Arizona Dental Association: The Arizona Dental Association has worked very closely with the Advisory Council on oral health issues in the past several years, and supports this effort to modernize and strengthen their role, charter and responsibilities.; Norris Nordvold, INTER TRIBAL COUNCIL OF ARIZONA: Updates changes to make council more representative and is supported by the Governor

HB2501, health regulatory boards; transfer; DHS

Testified in support:

Paul Avelar, INSTITUTE FOR JUSTICE AZ CHAPTER, Self; Christina Corieri, AZ GOVERNOR'S OFFICE

Testified as neutral:

Don Isaacson, AZ OPTOMETRIC ASSN; Jack Confer, Executive Director, AZ STATE BOARD OF RESPIRATORY CARE

Testified as opposed:

Cynthia Driskell, representing self

Support:

Shannon Whiteaker, AZ DEPT OF HEALTH SERVICES; Colby Bower, Arizona Department Of Health Services; Aimee Rigler, AZ FREE ENTERPRISE CLUB; Michael Hunter, BARRY GOLDWATER INSTITUTE FOR PUBLIC POLICY RESEARCH

Neutral:

Kevin Earle, Executive Director, Arizona Dental Association; Barry Aarons, AZ ASSOCIATION OF CHIROPRACTIC; Pete Wertheim, Arizona Osteopathic Medical Association; Tara Plese, AZ Alliance For Community Health Centers; Susan Cannata, The Arizona Academy Of Family Physicians; Scot Butler, Attorney, Arizona Occupational Therapy ASSN; Pele Fischer, AZ MEDICAL ASSN; Erica Mueller, representing self; Emily Jenkins, Arizona Council Of Human Service Providers; Fred Olsen, representing self; Susan Cannata, Arizona Athletic Trainers Association; Courtney McKinstry, AZ ATTORNEY GENERAL'S OFFICE

Oppose:

Lori Scott, representing self; Amanda Rusing, Arizona Physical Therapy Association

All Comments:

Shannon Whiteaker, AZ DEPT OF HEALTH SERVICES: Alternate will be speaking.; Paul Avelar, INSTITUTE FOR JUSTICE AZ CHAPTER, Self: Regulatory boards made up of market participants have an inherent conflict of interest to benefit themselves to the public's detriment. Following the Supreme Court's decision in the Dental Examiners case, Arizona must reform all its boards.; Cynthia Driskell, Self: The Arizona Physical Therapy Association opposes HB 2501. We have concerns that it will increase administrative burden and costs for PT licensees and PTA certificate holders. There is significant oversight in place for actions of the Board of PT.; Kevin Earle, Arizona Dental Association: The Arizona Dental Assn. believes that the Carter amendment providing for a study moves this initiative in the right direction. Auditor General study should determine if board fees are sufficient, insufficient or excessive.; Scot Butler, Arizona Occupational Therapy ASSN: Support the amendment; Emily Jenkins, Arizona Council Of Human Service Providers: There needs to be a broad and inclusive stakeholder process.; Fred Olsen, Self: with changes we support

HB2640, appropriation; pediatric neurological autoimmune disorders

Testified in support:

Paul Ryan, representing self

Support:

Jason Bezozo, Senior Program Director, Government Relations, BANNER HEALTH ARIZONA; kari kling, representing self; Shelley Matin, representing self; samantha Dittmar, representing self; Kate Fleck, representing self; Daniel Twibell, representing self; Karen Twibell, representing self; Helen Powell, representing self; Bethany Powell, representing self; Alexander Edwards, representing self; Clinton Powell Jr., representing self; Clinton Powell, representing self; Molly Ochoa, representing self; Jessica Smith, representing self; Patricia DayRyan, representing self

Neutral:

Shannon Whiteaker, AZ DEPT OF HEALTH SERVICES

All Comments:

kari kling, Self: Strong supporter! Please pass this bill!; Paul Ryan, Self: Would like to speak for the PACE Foundation and the hundreds of families it represents. We strongly support this bill and the research it enables to cure diseases like Pans and Pandas. Thanks you; Shelley Matin, Self: I strongly support this bill!; Kate Fleck, Self: I strongly support this much needed bill to address the growing number of kids being diagnosed with autoimmune neurological disorders; Daniel Twibell, Self: I strongly support this bill and encourage you to support it.; Karen Twibell, Self: Please support this bill; Helen Powell, Self: please pass the bill on behalf of all of our children; Molly Ochoa, Self: please support this bill to help the children and families afflicted by these autoimmune diseases; Patricia DayRyan, Self: please support this bill to help the kids and families in AZ suffering from these diseases

HB2667, dental care; treatment; volunteer care

Support:

Gibson McKay, FGA ACTION; Kathleen Pagels, Arizona Health Care Association

Neutral:

Stuart Goodman, Arizona Board Of Dental Examiners; Kevin Earle, Executive Director, Arizona Dental Association; Tara Plese, AZ Alliance For Community Health Centers; Fred Olsen, representing self; John MacDonald, Arizona Dental Association

Oppose:

Erica Mueller, representing self

All Comments:

Kevin Earle, Arizona Dental Association: The Arizona Dental Assn. does have some concerns that we believe can be worked out; Gibson McKay, FGA ACTION: We have worked with the Dental Assn and will continue to do so; Fred Olsen, Self: with changes we support; John MacDonald, Arizona Dental Association: The AZ Dental Association has some concerns with the original draft of the bill, but believes these issues can be addressed on the floor.

HB2307, anatomical gifts; procurement organizations; licensure

Testified in support:

John Cover, representing self; Gregory Harris, Donor Network Of Arizona

Testified as neutral:

Barry Aarons, ALCOR LIFE EXTENSION FOUNDATION

Testified as opposed:

Don Isaacson, Science Care

Support:

Robert Turner, representing self; Kathryn Senseman, United Tissue Network; Courtney McKinstry, AZ ATTORNEY GENERAL'S OFFICE; Garland Shreves, representing self; Michael Haener, Partner, RESEARCH FOR LIFE, TRANSPLANT FOR LIFE

Neutral:

Jennifer Carusetta, HEALTH SYSTEM ALLIANCE OF ARIZONA; Amanda Rusing, Arizona Bio Industry Association

All Comments:

Robert Turner, Self: Robert Turner, President and CEO of American Tissue Services Foundation, in support of HB2307.; Barry Aarons, ALCOR LIFE EXTENSION FOUNDATION: neutral with amendments; Kathryn Senseman, United Tissue Network: Support with amendment. Want to continue to work with stakeholders to resolve some outstanding drafting issues with the amendment.; Courtney McKinstry, AZ ATTORNEY GENERAL'S OFFICE: Our Office is supportive of this bill with the amendment and agreements to work together as this bill moves through the process.; Gregory Harris, Donor Network Of Arizona: Donor Network of Arizona supports HB2307 with the amendment.

HB2361, technical correction; state land; sale

Support:

Anne Dennis, representing self; Julie Hoffman, representing self; American Diabetes Assn ADA, representing self

Oppose:

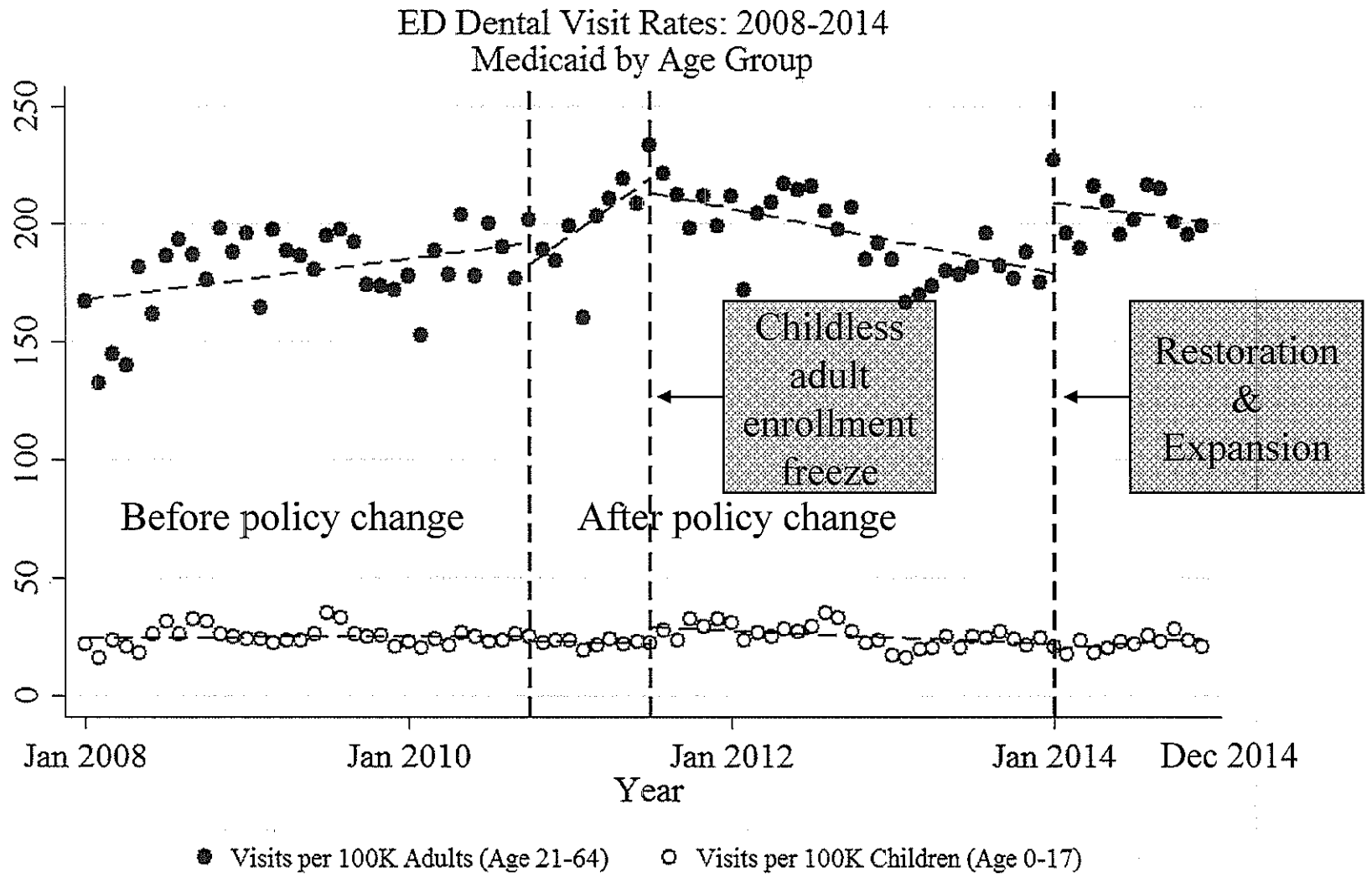
Gibson McKay, AZ CHILD CARE ASSOCIATION; Erin Raden, Arizona Child Care Association

All Comments:

Gibson McKay, AZ CHILD CARE ASSOCIATION: The underlying bill was just brought to our attention yesterday and unfortunately we have not had the chance to work with the other stakeholder. We would be happy to work with them in the interim; Julie Hoffman, Self: Eighteen years ago I desperately begged for help from the Southern and Central AZ child care associations, hoping to find a Type 1 diabetes friendly daycare for my 18 mo old daughter. There weren't any then and there aren't any now.

Arizona Medicaid adult dental ED visits

THE UNIVERSITY OF ARIZONA ARIZONA HEALTH SCIENCES CENTER
Center for Population Science & Discovery



Source: Arizona Department of Health Services (ADHS) Hospital Discharge Data 2008-2014. Dental visit identified as a primary diagnosis with ICD-9 codes: 521.00-521.99, 522.00-522.99, 523.00-523.99, 525.00-525.99, 528.00-528.99

Attachment 3

HOUSE OF REPRESENTATIVES

HB 2307

anatomical gifts; procurement organizations; licensure
Prime Sponsor: Representative Cobb, et al., LD 5

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2307 requires procurement organizations for anatomical gifts to be licensed by the Arizona Department of Health Services (ADHS).

PROVISIONS

1. Allows monies to be placed in the Health Services Licensing Fund (Fund) from licensing fees collected pursuant to § 36-851.01 (procurement organizations; licensure; renewal; fees; penalties).
2. Requires the procurement organization to refer the gift and all relevant donation information to another procurement organization in a manner that ensures the gift is recovered for transplantation if an anatomical gift is suitable for transplantation and the procurement organization is unable or unwilling to recover the tissue.
3. Prohibits a person from acting as a procurement organization in this state unless the person is licensed by ADHS as a procurement organization. The person must apply in writing to the Director of ADHS on a form specified by the Director, must include all information requested in the application and must pay the prescribed fees.
4. Requires the Director to grant a procurement organization license to a person if the organization either is registered or regulated by the federal government and is subject to inspection or meets the prescribed requirements and the rules adopted by ADHS.
5. States a license is valid for two years and must be renewed every two years. A person must file an application for renewal at least 30 days before the expiration of the current license.
6. Stipulates that each procurement organization applying for licensure or renewal must pay all applicable fees. All fees collected for the licensure or renewal of procurement organizations must be deposited into the Fund.
7. Allows the Director to sanction, impose civil penalties, suspend or revoke, in whole or in part, the license of any procurement organization if any person who is an owner, officer, agent or employee of the procurement organization is in or continues to be in violation of this article or the rules of ADHS.
8. Requires each procurement organization to do all of the following:
   a. Designate a medical director who is a licensed physician and who provides medical guidance to determine donor eligibility;

b. Employ a director who holds at least a bachelor's degree in a related science from an accredited university and who is responsible for all licensed activities of the organization; and
c. Implement and maintain all of the following:
   i. Standard operating procedures for all licensed functions of the organization;
   ii. A safety awareness and blood-borne pathogen training program that complies with state and federal law; and
   iii. A cleaning program that mitigates potential cross-contamination between donors.
d. Provide a designated area for tissue recovery that:
   i. Is open to inspection by ADHS with or without notice; and
   ii. Does not operate in a funeral establishment for the recovery of whole bodies for medical research and education.
e. Properly track donors and label tissue by doing both of the following:
   i. Assigning a unique identifying number to each donor and using this number for all tissue from that donor that is recovered and distributed; and
   ii. Affixing labels with the following information on all non-transplant tissue specimens:
      - A statement that universal precautions will be used;
      - A statement that the specimen is not for transplant or clinical use;
      - Any condition or limitation regarding the use of the specimen; and
      - Contact information for the procurement organization.
   iii. Maintain the following records for ten years after the last date of tissue distribution:
      - A copy or recorded consent of the donation authorization;
      - A copy of the donor's death certificate and transit permit issued by the state where the death occurred;
      - A copy of the donor's physical assessment and risk assessment questionnaire;
      - A copy of the donor's serological results, when applicable; and
      - A copy of all documentation relating to tissue recovery, storage and distribution activities.

9. Mandates that a procurement organization must be allowed direct access to all of the information in the records of the donor registry to determine if an individual who is at or near death is a donor.

10. Requires each hospital in this state to enter into a contract with all procurement organizations in this state that request a contract for the coordination of procurement and use of anatomical gifts to ensure that all donation opportunities are recovered.

11. Stipulates that each county medical examiner must enter into a contract with all procurement organizations that request a contract for the coordination of procurement and use of anatomical gifts to ensure that all donation opportunity are recovered.

12. States for purposes of this act, ADHS must adopt rules relating to the licensure of procurement organizations and enforcement of those provisions. Exempts ADHS from the rule making requirements.

13. Amends the definitions of *eye bank, organ procurement organization, procurement organization, tissue,* and *tissue bank.*

CURRENT LAW

A.R.S. § 36-850 specifies that an anatomical gift may be made to the following named in the document of gift: an organ procurement organization, a hospital, accredited medical school,

dental school, college, university, procurement organization or any other appropriate person for research or education; an individual designated by the person making the donation; and an eye bank or a tissue bank.

A.R.S. § 36-852 outlines the rights and duties of procurement organizations and others. When a hospital refers an individual at or near death to an organ procurement organization, the organization must make a reasonable search of the records of any donor registry that it knows exists to determine if the individual has made an anatomical gift. A procurement organization must be allowed reasonable access to information in the records of the donor registry to determine if an individual at or near death is a donor.

A.R.S. § 36-853 states each hospital in this state must enter into one or one or more agreements or affiliations with procurement organizations for coordination or procurement and use of anatomical gifts. If there has been an anatomical gift, the institution where the removal of any donated body parts occurs must notify the funeral director or the person acting in that capacity who first assumes custody of the body about removal of the body parts.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2307

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2307

(Reference to printed bill)

Page 1, strike lines 11 through 45
Strike pages 2 through 5
Page 6, strike lines 1 through 15
Renumber to conform
Line 19, after "penalties" insert "; exceptions"
Lines 27 and 28, strike "REGISTERED OR REGULATED BY THE FEDERAL GOVERNMENT AND IS SUBJECT TO INSPECTION" insert "ACCREDITED BY A NATIONALLY RECOGNIZED ACCREDITING AGENCY THAT IS APPROVED BY THE DEPARTMENT"
After line 43, insert:

"F. THIS SECTION DOES NOT APPLY TO EITHER OF THE FOLLOWING:

1. AN ORGAN PROCUREMENT ORGANIZATION AS DESCRIBED BY 42 UNITED STATES CODE SECTION 273 THAT IS DESIGNATED FOR THIS STATE BY THE SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES PURSUANT TO 42 UNITED STATES CODE SECTION 1320b-8.

2. A PROCUREMENT ORGANIZATION THAT IS REGULATED BY THE UNITED STATES FOOD AND DRUG ADMINISTRATION IN CONNECTION WITH THE RECOVERY OF HUMAN TISSUE INTENDED FOR TRANSPLANTATION PURSUANT TO 21 CODE OF FEDERAL REGULATIONS PART 1270."

Page 7, line 2, after "ORGANIZATION" insert "THAT IS REQUIRED TO BE LICENSED PURSUANT TO SECTION 36-851.01"
Strike pages 8 and 9
Page 10, strike lines 1 through 4
Renumber to conform
Amend title to conform

HEATHER CARTER

2307CARTER
02/15/2016
9:20 AM
C: MJH

Attachment 5

Adopted ✓ # of Verbals _____
Failed _____ Withdrawn _____
Not Offered _____ Analysts Initials ___

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2307

DATE February 16, 2016 MOTION: dpa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 6

HOUSE OF REPRESENTATIVES

HB 2501

health regulatory boards; transfer; DHS
Prime Sponsor: Representative Carter, LD 15

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2501 specifies that the Arizona Department of Health Services (ADHS) succeeds to the administrative authority of specified health professional regulatory boards (Boards).

PROVISIONS

1. Specifies that ADHS succeeds to the administrative authority of the following Boards in the following fiscal years (FYs):
   a. In FY 2017:
      i. Acupuncture Board of Examiners;
      ii. State Board of Dispensing Opticians;
      iii. Board of Homeopathic and Integrated Medicine Examiners;
      iv. Board of Occupational Therapy Examiners; and
      v. Board of Respiratory Care Examiners.
   b. In FY 2018:
      i. State Board of Podiatry Examiners;
      ii. Naturopathic Physicians Medical Board;
      iii. State Board of Optometry;
      iv. Board of Physical Therapy;
      v. State Board of Chiropractic Examiners; and
      vi. Medical Radiologic Technology Board of Examiners.
   c. In FY 2019:
      i. Arizona Board of Osteopathic Examiners in Medicine and Surgery;
      ii. State Board of Dental Examiners; and
      iii. Board of Behavioral Health Examiners.
   d. In FY 2020:
      i. Arizona Regulatory Board of Physician Assistants;
      ii. Arizona State Board of Nursing; and
      iii. Arizona Medical Board.
2. Beginning on the effective date of this section, a Board may not enter into any new contract or renew any existing contract without the approval of the Director of ADHS.
3. States this act does not alter the effect of any actions taken or impair the valid obligations of the Boards before July 1 of the respective FY.
4. Provides all administrative matters and contracts, whether completed, pending or in progress, of a Board on July 1 in the respective fiscal year are transferred to and retain the same status with ADHS.

5. Stipulates all certificates, licenses, registrations, permits and other indicia of qualifications and authority that were issued by a Board retain their validity for the duration of their terms of validity as provided by law.
6. States all tangible and intangible property and assets, all obligations and all data and investigative findings of the Boards are transferred to ADHS in the respective FY.
7. Specifies all personnel under the state personnel system who are employed by a Board are transferred in the respective FY to comparable positions and pay classifications in ADHS.
8. Defines *board.*
9. Contains a legislative intent clause.
10. Requires legislative council to prepare proposed legislation conforming the Arizona Revised Statutes to the provisions of this act for consideration by the legislature.

CURRENT LAW

Title 32 contains the laws related to professions and occupations. Included therein are education and licensing requirements along with the regulatory provisions.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2501

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2501

(Reference to printed bill)

Page 1, between lines 1 and 2, insert:

"Section 1. Title 36, chapter 1, article 1, Arizona Revised Statutes, is amended by adding section 36-116, to read:

36-116. Director; review of board proposed rules; final board decisions; definition

A. BEFORE A HEALTH PROFESSION REGULATORY BOARD FILES A PROPOSED RULE WITH THE GOVERNOR'S REGULATORY REVIEW COUNCIL, THE DIRECTOR SHALL REVIEW THE PROPOSED RULE. THE DIRECTOR MAY REJECT A PROPOSED RULE IF THE PROPOSED RULE EITHER:

1. WOULD HAVE A MATERIAL ANTICOMPETITIVE EFFECT AND THE PROPOSED RULE IS NOT NECESSARY TO PROTECT PUBLIC HEALTH AND SAFETY, UNLESS THE PROPOSED RULE IS REQUIRED BY LAW.

2. WOULD HAVE A MATERIAL ANTICOMPETITIVE EFFECT AND THERE IS A LESS RESTRICTIVE MEANS AVAILABLE TO PROTECT PUBLIC HEALTH AND SAFETY.

B. THE DIRECTOR MAY REVIEW ANY FINAL DECISION OF A HEALTH PROFESSION REGULATORY BOARD ON REQUEST BY ANY PARTY AS DEFINED IN SECTION 41-1001 WITHIN FIFTEEN DAYS AFTER THE BOARD'S FINAL DECISION IS MADE.. THE DIRECTOR SHALL COMPLETE THE REVIEW OF THE FINAL DECISION WITHIN THIRTY DAYS AND MAY OVERTURN THE DECISION FOR ANY OF THE FOLLOWING REASONS:

1. THE DECISION WOULD HAVE A MATERIAL ANTICOMPETITIVE EFFECT AND IS NOT NECESSARY TO PROTECT PUBLIC HEALTH AND SAFETY, UNLESS THE DECISION IS REQUIRED BY LAW.

2. THE DECISION WOULD HAVE A MATERIAL ANTICOMPETITIVE EFFECT AND THERE IS A LESS RESTRICTIVE MEANS AVAILABLE TO PROTECT PUBLIC HEALTH AND SAFETY.

C. IF THE DIRECTOR REJECTS A PROPOSED RULE OR OVERTURNS A FINAL DECISION OF A HEALTH PROFESSION REGULATORY BOARD, THE DIRECTOR SHALL REMAND

Attachment 8

Adopted ✓ # of Verbals ____
Failed ____ Withdrawn ____
Not Offered ____ Analysts Initials ____

THE DECISION BACK TO THE BOARD WITH A WRITTEN EXPLANATION TO THE BOARD OF THE REASONS SUPPORTING THE DECISION.

D. IF THE DIRECTOR FAILS TO COMPLETE THE REVIEW OF THE HEALTH PROFESSION REGULATORY BOARD'S FINAL DECISION WITHIN THIRTY DAYS AS REQUIRED IN SUBSECTION B OF THIS SECTION, THE DECISION OF THE BOARD STANDS.

E. FOR THE PURPOSES OF THIS SECTION, "HEALTH PROFESSION REGULATORY BOARD" MEANS ANY BOARD THAT ISSUES A CERTIFICATE, LICENSE, PERMIT OR REGISTRATION TO A PERSON PURSUANT TO TITLE 32, CHAPTER 7, 8, 11, 13, 14, 15, 15.1, 16, 17, 19, 19.1, 25, 28, 29, 33, 34, 35, 39 OR 41."

Renumber to conform

Page 1, between lines 11 and 12, insert:

"(e) Board of athletic training."

Reletter to conform

Line 13, strike "2017-2018" insert "2018-2019"

Line 21, strike "2018-2019" insert "2019-2020"

Line 25, strike "2019-2020" insert "2020-2021"

Line 31, after "contract" insert "that extends beyond July 1 of the respective fiscal year prescribed in subsection A of this section for that board"

Page 2, line 12, strike "or" insert a comma; after "39" insert "or 41,"

Between lines 13 and 14, insert:

"Sec. 3. Health profession regulatory boards; executive director; vacancy; delayed repeal

A. Notwithstanding any other law, after the transfer of the acupuncture board of examiners, the state board of dispensing opticians, the board of homeopathic and integrated medicine examiners, the board of occupational therapy examiners, the board of athletic training and the board of respiratory care examiners to the department of health services in fiscal year 2016-2017, if there is a vacant staff position for an executive director of one of these boards, the respective board may recommend candidates for that position to the director of the department of health services who shall make the final decision on the replacement of the position. Each executive director shall serve at the pleasure of the director of the department of health services.

B. This section is repealed from and after December 31, 2019.

Sec. 4. Department of health services; study; report; delayed repeal

A. On or before July 1, 2018, the department of health services shall complete a study relating to the transfer of the acupuncture board of examiners, the state board of dispensing opticians, the board of homeopathic and integrated medicine examiners, the board of occupational therapy examiners, the board of athletic training and the board of respiratory care examiners to the department. While the department is conducting the study, the department shall hold at least one hearing to receive public comments. The study shall address at least the following:

1. Individual and combined board staffing recommendations, including staffing levels and salaries.

2. The consolidation of administrative functions.

3. Areas in which greater efficiencies and cost-effectiveness may be realized.

4. Possibilities for integrating procedures and practices among the boards.

B. The department of health services shall present a report of the study to the house of representatives health committee of reference and the senate health and human services committee of reference, or their successor committees, on or before September 1, 2018. The committee of reference shall make legislative recommendations regarding the continuing transfer of health profession regulatory boards to the department of health services and for any necessary statutory changes.

C. This section is repealed from and after December 31, 2018.

Sec. 5. Auditor general study; report; delayed repeal

A. On or before July 1, 2018, the auditor general shall conduct a study to evaluate the structure, organization and operation of health profession regulatory boards as defined in section 36-116, Arizona Revised Statutes, as added by this act, and make recommendations regarding board processes that can be streamlined to benefit licensees and be more uniform among the boards while protecting public health and safety. The study shall include a comparison of at least the following:

1. Fees charged to persons who are regulated by each board.

2. Fingerprinting requirements for licensees.

3. The licensing processes of the board.

4. Disciplinary proceedings and the adjudication of licensees.

5. Investigative procedures.

6. Policies, procedures and practices that could apply uniformly to the boards.

7. Substance abuse programs for licensees.

8. Streamlining the sunset review process of the boards.

B. The auditor general shall present a report of the study to the house of representatives health committee of reference and the senate health and human services committee of reference, or their successor committees, on or before September 1, 2018. The committee of reference shall make legislative recommendations for any necessary statutory changes.

C. This section is repealed from and after December 31, 2018."

Renumber to conform

Page 2, strike lines 20 through 23

Amend title to conform

HEATHER CARTER

2501CARTER
02/15/2016
10:24 AM
C: MJH

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2501

DATE February 16, 2016 MOTION: dpa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer	✓	✓			
Mr. Friese			✓		
Mr. Lawrence		✓			
Mr. Meyer	✓		✓		
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		4	2	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 9

HOUSE OF REPRESENTATIVES

HB 2312

advisory council; Indian health care.
Prime Sponsor: Representative Hale, LD 7

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2312 updates the Arizona Advisory Council (Council) on Indian health care's membership and duties.

PROVISIONS

1. Includes a purpose statement for the Council.
2. Outlines Council membership as follows:
   a. Twenty-two representatives of the federally recognized American Indian tribes in Arizona who are appointed by the Governor. Each federally recognized American Indian tribe in Arizona must recommend to the Governor the names of persons to represent the tribe on and for appointment to the Council. Recommendations must be submitted by the tribe. Recommended representatives may have experience serving the elderly, youth, children or families or persons with disabilities.
   b. One representative from the Inter-tribal Council of Arizona who is recommended by the President of the Inter-tribal Council of Arizona and who is appointed by the Governor.
   c. One representative from an urban Indian health organization in Arizona that receives Indian health services funding who is recommended jointly by the urban Indian health organizations and who is appointed by the Governor.
   d. One representative from the Arizona Health Care Cost Containment System (AHCCCS) who is appointed by the Director of AHCCCS (existing member).
   e. One representative from the Arizona Department of Health Services (ADHS) who is appointed by the Director of ADHS (existing member).
   f. One representative from the Arizona Department of Economic Security (ADES) who is appointed by the Director of ADES (existing member).
   g. One representative from the Arizona Early Childhood Development and Health Board (Board) who is appointed by the Executive Director of the Board.
3. Requires a majority of the Council members to be members of federally recognized American Indian tribes in Arizona.
4. Requires the Council to invite federal representatives of the Centers for Medicare and Medicaid Services, the Indian Health Service, the United States Social Security Administration and the United States Department of Veterans Affairs to serve as technical advisors to the Council. These representatives must be ex-officio members and may serve a three year term on the Council.
5. Prohibits a member of the Council from being an employee of the state, except the representatives from AHCCCS, ADHS, ADES and the Board.

6. Clarifies that members are not eligible to receive compensation, but are eligible for reimbursement of expenses.
7. Changes the term of appointed members from two years to three years.
8. Requires the Council to elect a Chairperson and Vice Chairperson from the persons appointed from:
   a. The federally recognized American Indian tribe in Arizona;
   b. The Inter-tribal Council of Arizona; and
   c. An urban Indian health organization.
9. Changes the election from the first Monday in October every year to the second Monday in July every other year.
10. Modifies the term of office from one year to two years.
11. Requires the Council to:
    a. Assist tribes and urban Indian health organizations to develop comprehensive medical and public health care delivery and financing systems to meet the needs of American Indian tribes in Arizona. In doing so the Council must:
       i. Recommend new Title XIX and XXI programs, services, funding options, policies and demonstration projects to meet the needs of American Indian tribes and urban Indian health organizations;
       ii. Facilitate communications, planning, advocacy and discussion among tribes and urban Indian health organizations in Arizona and with state and federal agencies regarding operations, financing, policy and legislation relating to Indian medical and public health care;
       iii. Recommend and advocate tribal, state and federal policy and legislation that support the design and implementation of medical and public health care delivery and financing systems for tribes and urban Indian health organizations in Arizona;
       iv. Conduct and commission studies and research to further the purpose of the Council and to address identified Indian health care disparities in Arizona;
       v. Conduct periodic public hearings to gather input and recommendations from tribal populations on their health care issues and concerns;
       vi. Apply for and seek grants, contracts and funding to further the purpose of the Council. Funding shall supplement and not diminish annual appropriations for the council; and
       vii. States that in conjunction with AHCCCS and a tribe that operates a Temporary Assistance for Needy Families (TANF) program, request a federal waiver from the United States Department of Health and Human Services that allows tribal governments that perform eligibility determinations for TANF programs to perform the Medicaid eligibility determinations.
12. States that all members currently serving on the Council may continue to do so until the expiration of their normal terms.
13. Makes technical and conforming changes.

CURRENT LAW

A.R.S. §§ 36-2902.01 and 36-2902.02 outline the current membership and duties of the Council.

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2312

DATE February 16, 2016 MOTION: dp

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 11

TESTIMONY ON HB 2312: ADVISORY COUNCIL; INDIAN HEALTH CARE

Arizona State Legislature
House of Representatives
Health Committee
February 16, 2016

Good afternoon, Madam Chair of the Health Committee, Representative Carter, Madam Vice-Chair, Representative Cobb and members of the Committee. My name is Alida Montiel. I am the Chairperson of the Advisory Council on Indian Health Care. I am a member of the Pascua Yaqui Tribe, a federally recognized Tribe and the Health Systems Director of the Inter Tribal Council of Arizona. I am joined today by Kim Russell, the Executive Director of the Advisory Council on Indian Health Care. She is a member of the Navajo Nation. Lorencita Joshweseoma of the Hopi Tribe is the Vice-chair. She's not able to join us today. I was originally appointed to the Council by former Governor Fife Symington in 1995.

We are seeking your support to pass HB 2312. The original Arizona Revised Statutes that contain the membership and duties of the Council were signed into law in 1989. While the Council has been in operation for the last 27 years, the Tribal government, urban Indian program representatives and other members of the Council have now carefully examined what improvements are needed statutorily so that the Council may improve its operations and meet its responsibilities as we continue to convene representatives of the Indian Nations and Tribes, urban Indian health programs and state and federal agencies that seek to assure improved health outcomes of the approximate 300,000 American Indian people that reside in this state and on Tribal lands.

This is proud moment for the Council and its staff. We've worked very hard on developing these amendments. As a state agency, it was also our duty to consult with the Tribes in Arizona and the stakeholders we serve. The consultation meeting was held last summer. In addition to our six meetings per year and committee meetings, all held under the purview of the required open meeting law, Ms. Russell has been requested by Tribes to meet with their Tribal Councils on this issue. To date, six Tribes have adopted resolutions of support. They are the Havasupai Tribe, the Gila River Indian Community, the Hopi Tribe, Navajo Nation, Tohono O'odham Nation and the Pascua Yaqui Tribe. More of these sessions with Tribes are scheduled. The appointments to the Council are made by the Arizona Governor once a nomination is received from a Tribe, Tribal organization or urban Indian health program. It was important to meet with the Governor's staff in this process, in particular, the Health Policy Advisor, the Tribal Liaison and the Director of Boards and Commissions to provide them the background information about the Council and to discuss their recommendations on the language that would be developed into a bill. We have done our homework and believe we have a solid bill.

With your help we'll continue to expand our accomplishments. These include providing on going advisement to the state agencies in terms of health and human service policy and program implementation that uniquely effects Tribes, working with our state and federal representatives on such issues as increasing the number of American Indians in health careers, addressing behavioral health services that are extended to reservation areas through the RBHA/TRBHA systems and health care

Attachment 12

coordination that involves the Indian Health Service, Tribes and Urban Indian health programs, we term I/T/U and the policies relating to insurance coverage and reimbursement.

Thank you for this opportunity. I or Ms. Russell will answer any of your questions.

Alida Montiel, Chairperson
Arizona Advisory Council on Indian Health Care
Health Systems Director
Inter Tribal Council of Arizona
2214 N. Central Avenue
Phoenix, Arizona 85004
Office: 602-258-4822 Ext. 1575
Fax: 602-258-4825
Alida.Montiel@itcaonline.com

Kim Russell, Executive Director
Arizona Advisory Council on Indian Health Care
1740 W. Adams Street, Suite 409,
Phoenix, Arizona 85007
Office: 602-542-5725
Fax: 602-542-5761
Kim.Russell@azahcccs.gov

HAVASUPAI TRIBAL COUNCIL
P.O. Box 10 • Supai, Arizona 86435
(928) 448-2731 • Fax (928) 448-2551

Resolution No. 59-15

Support for the Arizona Advisory Council on Indian Health Care

Statute Amendments

WHEREAS, the Arizona Advisory Council on Indian Health Care (AACOIHC) was established in 1989 by the Arizona State Legislature; and,

WHEREAS, the members of the AACOIHC are appointed by the Governor of the State of Arizona and are comprised of representatives of Tribal governments, and Tribal and Urban Indian health organizations; and,

WHEREAS, the mission of the AACOIHC is to, "Advocate for wellness and access to high quality healthcare for all American Indians in Arizona" with regard to the development of Tittle XIX (Medicaid) and Title XXI (Children's Health Insurance Program) demonstration programs, services, and polices; and,

WHEREAS, the AACOIHC statutes provide authorities to the AACOIHC to recommend and advocate for health care related policy and legislation in Arizona that will beneficially impact Tribes in Arizona; and,

WHEREAS, the AACOIHC is one of two state agencies/commissions of the Arizona State government that work directly with Tribal governments in Arizona to address American Indian issues and concerns; and,

WHEREAS, the relationship between the State of Arizona and Tribes is important for collaborative governance to elevate the health status of all American Indians in Arizona, who comprise 5.3% of the population, but who have the most significant and disproportionate rates of health disparities of any racial or ethnic group in the state; and,

WHEREAS, the hopes of the Tribes in Arizona envisioned with the establishment of the AACOIHC in 1989 have begun with Tribes leading efforts to develop and implement comprehensive health care delivery and financing systems on behalf of their communities; and,

WHEREAS, the role of the AACOIHC has evolved over the last 26 years and changes in federal and state health care polices and program development efforts of Tribes and urban Indian health programs now require the AACOIHC statutes reflect these changes; and,

WHEREAS, the AACOIHC has solicited feedback and recommendations to amend ARS 36-2902.01 and ARS 36-2902.02 from Tribes in Arizona during a half day Tribal Consultation Meeting on Monday, June 15, 2015 and through a 45-day open comment process; and,

WHEREAS, the AACOIHC seek that legislation be entered into the Arizona State Legislature in the 2016 legislative session to amend A.R.S. 36-2902.01 and A.R.S. 36-2902.02 to be current and supportive of Tribes and urban Indian organizations in Arizona and their progressive and evolving medical and public health care systems.

THEREFORE BE IT RESOLVED THAT the **Havasupai Tribe** supports the amendments to update A.R.S. 36-2902.01 and A.R.S. 36-2902.02.

THEREFORE BE IT FURTHER RESOLVED THAT the Tribal Council appoints Council Member **Thomas Siyuja Sr.** to represent the Havasupai Tribe at all meetings on this matter.

CERTIFICATION

The foregoing Resolution is adopted pursuant to the authority of Article V, Section 1 of the Amended Constitution of the Havasupai Tribe, a federally recognized sovereign Indian Tribe and Article II of the Bylaws of the Havasupai Tribe at the Special Council meeting of the Tribal Council on the 11th day of November, 2015 by a vote of **4** for; **0** opposed and **0** abstained.

HAVASUPAI TRIBAL COUNCIL:

By: _____

Roland Manakaja, Vice-Chairman

ATTEST:

_____

Tribal Secretary

RESOLUTION OF THE TOHONO O'ODHAM LEGISLATIVE COUNCIL
(Support for the Arizona Advisory Council on Indian Health Care Statute Amendments)

RESOLUTION NO. 15-488

WHEREAS, the Tohono O'odham Constitution vests the Legislative Council with the authority to "promote, protect and provide for public health, peace, morals, education and general welfare of the Tohono O'odham Nation and its members" and to "consult, negotiate and conclude agreements and contracts on behalf of the Tohono O'odham Nation with Federal, State and local governments. . ." (Constitution, Article VI, Section 1(c)(2) and Section 1(f)); and

WHEREAS, the Arizona Advisory Council on Indian Health Care ("AACOIHC") was established in 1989 by the Arizona State Legislature; and

WHEREAS, the members of the AACOIHC are appointed by the Governor of the State of Arizona and are comprised of representatives of tribal governments, and tribal and urban Indian health organizations; and

WHEREAS, the mission of the AACOIHC is to, "Advocate for wellness and access to high quality healthcare for all American Indians in Arizona" with regard to the development of Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) demonstration programs, services, and polices; and

WHEREAS, the AACOIHC statutes provide authorities to the AACOIHC to recommend and advocate for health care related policy and legislation in Arizona that will beneficially impact tribes in Arizona; and

WHEREAS, the AACOIHC is one of two state agencies/commissions of the Arizona State government that work directly with tribal governments in Arizona to address American Indian issues and concerns; and

WHEREAS, the relationship between the State of Arizona and tribes is important for collaborative governance to elevate the health status of all American Indians in Arizona, who comprise 5.3% of the population, but who have the most significant and disproportionate rates of health disparities of any racial or ethnic group in the state; and

WHEREAS, the establishment of the AACOIHC in 1989 began with tribes leading efforts to develop and implement comprehensive health care delivery and financing systems on behalf of their communities; and

WHEREAS, the role of the AACOIHC has evolved over the last 26 years and changes in federal and state health care polices and program development efforts of tribes and

urban Indian health programs now require the AACOIHC statutes reflect these changes; and

WHEREAS, **the AACOIHC solicited feedback and recommendations to amend Arizona Revised Statutes ("A.R.S.") 36-2902.01 and A.R.S. 36-2902.02 from tribes in Arizona during a half day Tribal Consultation Meeting on Monday, June 15, 2015 and through a 45-day open comment process; and**

WHEREAS, **the AACOIHC urges the Arizona State Legislature in the 2016 legislative session to amend A.R.S. 36-2902.01 and A.R.S. 36-2902.02 to be current and supportive of tribes and urban Indian organizations in Arizona and their progressive and evolving medical and public health care systems; and**

WHEREAS, **the Health and Human Services Committee recommends supporting the AACOIHC amendments to update A.R.S. 36-2902.01 and A.R.S. 36-2902.02.**

NOW, THEREFORE, BE IT RESOLVED by the Tohono O'odham Legislative Council that it supports the AACOIHC amendments to update A.R.S. 36-2902.01 and A.R.S. 36-2902.02.

The foregoing Resolution was passed by the Tohono O'odham Legislative Council on the 10TH day of DECEMBER, 2015 at a meeting at which a quorum was present with a vote of 3,021.4 FOR; -0- AGAINST; -0- NOT VOTING; and [01] ABSENT, pursuant to the powers vested in the Council by Article VI, Sections 1(c)(2) and Section 1(f) of the Constitution of the Tohono O'odham Nation, adopted by the Tohono O'odham Nation on January 18, 1986; and approved by the Acting Deputy Assistant Secretary - Indian Affairs (Operations) on March 6, 1986, pursuant to Section 16 of the Act of June 18, 1934 (48 Stat.984).

TOHONO O'ODHAM LEGISLATIVE COUNCIL

Timothy Joaquin, Legislative Chairman

11 day of December, 2015

ATTEST:

Evonne Wilson, Legislative Secretary

11 day of December, 2015

Said Resolution was submitted for approval to the office of the Chairman of the Tohono O'odham Nation on the 11 day of December, 2015 at 5:06 o'clock, P .m., pursuant to the provisions of Section 5 of Article VII of the Constitution and will become effective upon his approval or upon his failure to either approve or disapprove it within 48 hours of submittal.

TOHONO O'ODHAM LEGISLATIVE COUNCIL

Timothy Joaquin, Legislative Chairman

[✓] **APPROVED** **on the 11 day of December, 2015**

[ ] **DISAPPROVED** **at 6:02 o'clock, P .m.**

EDWARD D. MANUEL, CHAIRMAN
TOHONO O'ODHAM NATION

Returned to the Legislative Secretary on the 14 day of December, 2015, at 8:10 o'clock, a .m.

Evonne Wilson, Legislative Secretary

GILA RIVER INDIAN COMMUNITY

SACATON, AZ 85147

RESOLUTION GR-338-15

A RESOLUTION SUPPORTING THE ARIZONA ADVISORY COUNCIL ON INDIAN HEALTH CARE AND PROPOSED AMENDMENTS TO ARS 36-2902.01 AND ARS 36-2902.02

WHEREAS, the Gila River Indian Community Council (the "Community Council") is the governing body of the Gila River Indian Community (the "Community"), a federally recognized Indian tribe; and

WHEREAS, the Community Council is empowered by Article XV Section 1 (a) (9), of the Constitution and Bylaws of the Gila River Indian Community (approved March 17, 1960), to promote and protect the health, peace, moral, education and general welfare of the Community and its members; and

WHEREAS, the health and welfare of the Community is a high priority; and

WHEREAS, the Arizona Advisory Council on Indian Health Care (AACOIHC) was established in 1989 by the Arizona State Legislature; and

WHEREAS, the members of the AACOIHC are appointed by the Governor of the State of Arizona and are comprised of representatives of Tribal governments, and Tribal and Urban Indian health organizations; and

WHEREAS, the Community has had a representative member of the AACOIHC since January 2006; and

WHEREAS, the mission of the AACOIHC is to, "Advocate for wellness and access to high quality healthcare for all American Indians in Arizona" with regard to the development of Title XIX (Medicaid) and Title XXI (Children's Health Insurance Program) demonstration programs, services, and polices; and

WHEREAS, the AACOIHC statutes authorize the AACOIHC to recommend and advocate for health care related policy and legislation in Arizona that will beneficially impact Tribes in Arizona; and

WHEREAS, the AACOIHC is one of two state agencies/commissions of the Arizona State government that work directly with Tribal governments in Arizona to address American Indian issues and concerns; and

WHEREAS, the relationship between the State of Arizona and Tribes is important for collaborative governance to elevate the health status of all American Indians in Arizona, who comprise 5.3% of the population, but who have the most significant

and disproportionate rates of health disparities of any racial or ethnic group in the state; and

WHEREAS, the hopes of the Tribes in Arizona envisioned with the establishment of the AACOIHC in 1989 began with Tribes leading efforts to develop and implement comprehensive health care delivery and financing systems on behalf of their communities; and

WHEREAS, the role of the AACOIHC has evolved over the last 26 years and changes in federal and state health care polices and program development efforts of Tribes and urban Indian health programs now require the AACOIHC statutes to reflect these changes; and

WHEREAS, the AACOIHC has solicited feedback and recommendations to amend ARS 36-2902.01(Arizona Advisory Council on Indian Health Care; membership; compensation; meetings and purpose) and ARS 36-2902.02 (Arizona Advisory Council on Indian Health Care; duties) from Tribes in Arizona during a half day Tribal Consultation Meeting on Monday, June 15, 2015 and through a 45-day open comment process; and

WHEREAS, the AACOIHC is requesting the Arizona State Legislature in the 2016 legislative session amend ARS 36-2902.01 and ARS 36-2902.02, to be current and supportive of Tribes and urban Indian organizations in Arizona and their progressive and evolving medical and public health care systems; and

WHEREAS, it has been reported that there are vacancies on the AACOIHC because Arizona Governor Ducey has not been appointing individuals to board and commissions, including AACOIHC.

NOW, THEREFORE BE IT RESOLVED, the Community Council supports the amendments to ARS 36-2902.01 and ARS 36-2902.02, as proposed by the AACOIHC.

BE IT FURTHER RESOLVED, that the Community Council request Governor Lewis contact Arizona Governor Ducey to request Governor Ducey appoint individuals to fill the vacancies on the AACOIHC.

BE IT FURTHER RESOLVED, that the Community Council authorizes Public Policy Partners to assist the Community with any necessary lobbying and related efforts to amend ARS 36-2902.01 and ARS 36-2902.02.

BE IT FINALLY RESOLVED, that the Governor, or in the Governor's absence, the Lieutenant Governor, is authorized and directed to execute and sign the necessary documents to fulfill the intent of the resolution.

CERTIFICATION

Pursuant to authority contained in Article XV, Section **1, (a) (7), (9), (18),** and Section **4** of the amended Constitution and Bylaws of the Gila River Indian Community, ratified by the tribe January 22, 1960, and approved by the Secretary of the Interior on March 17, 1960, the foregoing resolution was adopted on the **02nd** of **December 2015,** at a regular Community Council meeting held in **District 3, Sacaton, Arizona** at which a quorum of **14** Members were present by a vote of: **13** FOR; **0** OPPOSE; **1** ABSTAIN; **2** ABSENT; **1** VACANCY.

GILA RIVER INDIAN COMMUNITY

GOVERNOR

ATTEST:

COMMUNITY COUNCIL SECRETARY

GILA RIVER INDIAN COMMUNITY
1939
ARIZONA

PASCUA YAQUI TRIBE

RESOLUTION NO. C02-20-16

RESOLUTION OF THE PASCUA YAQUI TRIBE SUPPORTING AMENDMENTS TO UPDATE ARIZONA STATE STATUTES PERTAINING TO THE ARIZONA ADVISORY COUNCIL ON INDIAN HEALTH CARE.

WHEREAS, the Tribal Council of the Pascua Yaqui Tribe is vested with the power to adopt Resolutions to protect and promote the health and general welfare of the Pascua Yaqui people, (Constitution of the Pascua Yaqui Tribe, Article VI, Section 1(o)); and

WHEREAS, the Tribal Council is aware of pending amendments to Arizona state statutes pertaining to the Arizona Advisory Council on Indian Health Care (AACOIHC); and

WHEREAS, the Tribal Council has concluded that the recommended amendments will update the AACOIHC and make it more effective in addressing healthcare issues affecting Arizona Indian Tribes ; and

WHEREAS, the Tribal Council has concluded it is appropriate to formally state its support for the recommended amendments to the Arizona state statutes pertaining to the AACOIHC; and

WHEREAS through this Resolution the Tribal Council formally states its support for the recommended amendments to the Arizona state statutes pertaining to the AACOIHC.

NOW THEREFORE BE IT RESOLVED BY THE TRIBAL COUNCIL OF THE PASCUA YAQUI TRIBE that it hereby formally states its support for the recommended amendments to the Arizona state statutes pertaining to the AACOIHC.

7474 S. Camino De Oeste • Tucson, Arizona 85757 • Phone (520) 883-5010 • FAX (520) 883-5075
1-888-443-0044

CERTIFICATION

THE FOREGOING was on **February 3, 2016** duly adopted by a vote of **Eleven** in favor, **Zero** opposed, and **Zero** abstained, by the Tribal Council of the Pascua Yaqui pursuant to authority vested in it by Article VI, Sections 1(a) and (k) of the Constitution of the Pascua Yaqui Tribe, as adopted on January 26, 1988 and approved by the Secretary of the Interior of February 8, 1988 pursuant to Section 16 of the Indian Reorganization Act of June 18, 1934 (48 Stat. 984).

CHAIRMAN OF THE PASCUA YAQUI TRIBE

SECRETARY OF THE PASCUA YAQUI TRIBE

**RESOLUTION OF THE
NAABIK'IYATI' COMMITTEE OF THE
NAVAJO NATION COUNCIL**

23RD Navajo Nation Council---First Year, 2015

AN ACTION

RELATING TO HEALTH, EDUCATION AND HUMAN SERVICES AND NAABIK'IYATI'; SUPPORTING AMENDMENTS TO ARIZONA STATE LAW, A.R.S. § 36-2902.01 AND A.R.S. § 36-2902.01, AS PROPOSED BY THE ARIZONA ADVISORY COUNCIL ON INDIAN HEALTH CARE

WHEREAS:

1. The Health, Education and Human Services Committee of the Navajo Nation Council, among other duties and responsibilities, "review[s] and recommend[s]... [r]esolutions relating to social services, health, environmental health, education, veterans and veterans services, employment and labor." 2 N.N.C. §401(B)(6)(a).

2. The Naabik'íyáti' Committee of the Navajo Nation Council, among other duties and responsibilities, "coordinate[s] all federal, county and state programs with other standing committees and branches of the Navajo Nation government to provide the most efficient delivery of services to the Navajo Nation. 2 N.N.C. §701(A)(4).

3. The Advisory Council on Indian Health Care was established under Arizona state law. Sections 36-2902.01 and 36-2902.02 of the Arizona Revised Statutes relates to the Advisory Council's membership and duties, respectively. The Advisory Council is proposing amendments to these sections. See Exhibit "A." Amendments to these sections will better serve the intent and purposes of the establishment of the Advisory Council as it relates to health care of all citizens in Arizona. Amendments will further define or otherwise clarify the duties and responsibilities of the Advisory Council in ensuring the health care is provided all Indian people in Arizona.

NOW THEREFORE BE IT RESOLVED:

The Navajo Nation supports amendments to A.R.S. §36-2902.01 and A.R.S. §36-2902.02, as proposed by the Arizona Advisory Council on Indian Health Care and as reflected in Exhibit "A" (attached hereto).

CERTIFICATION

I hereby certify that the foregoing resolution was duly considered by the Naabik'íyáti' Committee of the 23rd Navajo Nation Council at a duly called meeting in Twin Arrows Casino & Resort, Leupp (Arizona), at which a quorum was present and that the same was passed by a vote of in 16 favor and 0 oppose, this 3rd Day of December, 2015.

Honorable LoRenzo C. Bates, Chairperson
Naabik'íyáti' Committee

Motion : Leonard Tsosie
Second : Otto Tso

HOUSE OF REPRESENTATIVES

HB 2640

appropriation; pediatric neurological autoimmune disorders
Prime Sponsor: Representative Carter, et al., LD 15

X Committee on Health

Committee on Appropriations

Caucus and COW

House Engrossed

OVERVIEW

HB 2640 appropriates $1,000,000 from the state General Fund (GF) in Fiscal Year (FY) 2016 to the Arizona Department of Health Services (ADHS) to provide grants for the research, diagnosis and treatment of pediatric neurological autoimmune disorders.

PROVISIONS

1. Appropriates the sum of $1,000,000 from the state GF in FY 2016 to ADHS to provide grants on a competitive basis for the research, diagnosis and treatment of pediatric neurological autoimmune disorders.
2. Requires the Biomedical Research Commission to evaluate grant applications and make award recommendations to the director of ADHS.

CURRENT LAW

Laws 2015, Chapter 8, Section 50 appropriated monies to ADHS.

Fifty-second Legislature
Second Regular Session

Health
H.B. 2640

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2640

(Reference to printed bill)

Page 1, line 5, strike "$1,000,000" insert "$250,000"; strike "state general" insert "disease control research"; after "fund" insert "established by section 36-274, Arizona Revised Statutes,"

Line 8, strike ", diagnosis and treatment"

Amend title to conform

HEATHER CARTER

2640CARTER
02/15/2016
09:38 AM
C: mjh

Attachment 14

Adopted V # of Verbals _____
Failed _____ Withdrawn _____
Not Offered ____ Analysts Initials ___

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2640

DATE February 16, 2016 MOTION: dpa

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 15

HOUSE OF REPRESENTATIVES

HB 2061

medical marijuana; pregnancy exclusion
Prime Sponsor: Representative Townsend, et al., LD 16

X Committee on Health

Caucus and COW

House Engrossed

SUMMARY OF PROPOSED STRIKE-EVERYTHING AMENDMENT TO HB 2061

HB 2061 mandates the Arizona Department of Health Services (ADHS) to adopt rules requiring all non-profit medical marijuana dispensaries to display signs warning women about the dangers of smoking or ingesting marijuana during pregnancy.

PROVISIONS

1. Requires ADHS to adopt rules requiring each non-profit medical marijuana dispensary to display, in a conspicuous location, a sign that warns pregnant women about the dangers to fetuses caused by smoking or ingesting marijuana while pregnant and the risk of being reported to the Department of Child Safety during pregnancy or at the birth of the child by persons who are required to report.
2. Specifies the rules must include the specific warning language required on the sign.
3. States the costs and display of the sign required by rule must be borne by the non-profit medical marijuana dispensary.
4. Contains a Prop 105 clause.
5. Makes technical and conforming changes.

CURRENT LAW

Contained within Title 36, Chapter 28.1 are laws relating to the Arizona medical marijuana act. Included therein are requirements by which a person may receive a medical marijuana identification card. Registration and certification requirements are provided for the purpose of operating a nonprofit medical marijuana dispensary. Rulemaking requirements for the Arizona Department of Health Services are also provided.

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2061

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Subject to the requirements of article IV, part 1, section 1, Constitution of Arizona, section 36-2803, Arizona Revised Statutes, is amended to read:

36-2803. Rulemaking

A. ~~Not later than one hundred twenty days after the effective date of this chapter,~~ The department shall adopt rules:

1. Governing the manner in which the department ~~shall consider~~ CONSIDERS petitions from the public to add debilitating medical conditions or treatments to the list of debilitating medical conditions set forth in section 36-2801, paragraph 3, including public notice of, and an opportunity to comment in a public hearing ~~upon~~ ON, petitions.

2. Establishing the form and content of registration and renewal applications submitted under this chapter.

3. Governing the manner in which ~~it shall consider~~ THE DEPARTMENT CONSIDERS applications for and renewals of registry identification cards.

4. Governing nonprofit medical marijuana dispensaries, for the purpose of protecting against diversion and theft without imposing an undue burden on nonprofit medical marijuana dispensaries or compromising the confidentiality of cardholders, including:

(a) The manner in which the department ~~shall consider~~ CONSIDERS applications for and renewals of registration certificates.

Attachment 17

Adopted ✓ # of Verbals ____
Failed ____ Withdrawn ____
Not Offered ____ Analysts Initials ____

(b) Minimum oversight requirements for nonprofit medical marijuana dispensaries.

(c) Minimum recordkeeping requirements for nonprofit medical marijuana dispensaries.

(d) Minimum security requirements for nonprofit medical marijuana dispensaries, including requirements for protection of each registered nonprofit medical marijuana dispensary location by a fully operational security alarm system.

(e) Procedures for suspending or revoking the registration certificate of nonprofit medical marijuana dispensaries that violate ~~the provisions of~~ this chapter or the rules adopted pursuant to this section.

5. Establishing application and renewal fees for registry identification cards and nonprofit medical marijuana dispensary registration certificates, according to the following:

(a) The total amount of all fees shall generate revenues sufficient to implement and administer this chapter, except that fee revenue may be offset or supplemented by private donations.

(b) Nonprofit medical marijuana dispensary application fees may not exceed $5,000.

(c) Nonprofit medical marijuana dispensary renewal fees may not exceed $1,000.

(d) The total amount of revenue from nonprofit medical marijuana dispensary application and renewal fees and registry identification card fees for nonprofit medical marijuana dispensary agents shall be sufficient to implement and administer the nonprofit medical marijuana dispensary provisions of this chapter, including the verification system, except that the fee revenue may be offset or supplemented by private donations.

(e) The department may establish a sliding scale of patient application and renewal fees based ~~upon~~ ON a qualifying patient's household income.

(f) The department may consider private donations under section 36-2817 to reduce application and renewal fees.

B. THE DEPARTMENT SHALL ADOPT RULES THAT REQUIRE EACH NONPROFIT MEDICAL MARIJUANA DISPENSARY TO DISPLAY IN A CONSPICUOUS LOCATION A SIGN THAT WARNS PREGNANT WOMEN ABOUT THE DANGERS TO FETUSES CAUSED BY SMOKING OR INGESTING MARIJUANA WHILE PREGNANT AND THE RISK OF BEING REPORTED TO THE DEPARTMENT OF CHILD SAFETY DURING PREGNANCY OR AT THE BIRTH OF THE CHILD BY PERSONS WHO ARE REQUIRED TO REPORT. THE RULES SHALL INCLUDE THE SPECIFIC WARNING LANGUAGE THAT MUST BE INCLUDED ON THE SIGN. THE COST AND DISPLAY OF THE SIGN REQUIRED BY RULE SHALL BE BORNE BY THE NONPROFIT MEDICAL MARIJUANA DISPENSARY.

~~B.~~ C. The department is authorized to adopt the rules set forth in ~~subsection~~ SUBSECTIONS A AND B OF THIS SECTION and shall adopt those rules pursuant to title 41, chapter 6.

Sec. 2. Requirements for enactment; three-fourths vote

Pursuant to article IV, part 1, section 1, Constitution of Arizona, section 36-2803, Arizona Revised Statutes, as amended by this act, is effective only on the affirmative vote of at least three-fourths of the members of each house of the legislature."

Amend title to conform

PAUL BOYER

2061PB.doc
02/11/2016
10:30 AM
C: mjh

Fifty-second Legislature
Second Regular Session

Health
H.B. 2061

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2061

(Reference to the Boyer s/e amendment dated 2/11/2016; 10:30 AM)

Page 3, line 3, after "THE" insert "POTENTIAL"

Line 4, after "PREGNANT" insert "OR BREASTFEEDING"

Amend title to conform

RANDALL FRIESE

2061FRIESE
02/15/2016
11:13 AM
H: JH/rca

Attachment 16

Adopted ✓ # of Verbals _____
Failed _____ Withdrawn _____
Not Offered _____ Analysts Initials _____

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2061

DATE February 16, 2016 MOTION: dpas/e

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 19

HOUSE OF REPRESENTATIVES

HB 2361

technical correction; state land; sale
Prime Sponsor: Representative Carter, LD 15

X Committee on Health

Caucus and COW

House Engrossed

SUMMARY OF PROPOSED STRIKE-EVERYTHING AMENDMENT TO HB 2361

The proposed strike-everything amendment to HB 2361 allows the Arizona Department of Health Services (ADHS) to adopt policies and procedures that include diabetes medical management plans for children with diabetes on the premises of a child care facility.

PROVISIONS

1. Permits ADHS to adopt policies and procedures that include diabetes medical management plans for children who have been diagnosed with diabetes by a health care professional to manage diabetes for those children on the premises of child care facilities as authorized by a child's primary health professional.
2. States that if ADHS adopts policies and procedures, the policies and procedures must authorize child care facilities to adopt policies and procedures to manage diabetes for children who attend a child care facility and to designate two or more employees of each child care facility to serve as voluntary diabetes care assistants.
3. Stipulates that the parent or guardian of a child who has been diagnosed with diabetes and who attends a child care facility must have final approval of the child's voluntary diabetes care assistants. Permits voluntary diabetes care assistants to administer insulin to a child or administer glucagon to a child in an emergency situation, or both, if all of the following apply:
   a. The voluntary diabetes care assistant has provided to the child care facility a written statement signed by a health professional that the voluntary diabetes care assistant has received training in the administration of insulin and glucagon;
   b. A health professional if not immediately available to attend to the child at the time of the emergency;
   c. The voluntary diabetes care assistant is authorized to administer glucagon, the child's parent or guardian has provided the child care facility with an unexpired glucagon kit for the calendar year that is prescribed for that child by a health care professional; and
   d. The voluntary diabetes care assistant is authorized to administer insulin, the child's parent or guardian has provided the child care facility with insulin and all equipment and supplies that are necessary for insulin administration.
4. The training provided by a health professional to voluntary diabetes care assistants must include all of the following:
   a. An overview of all types of diabetes;
   b. The symptoms and treatment of hyperglycemia and hypoglycemia;

c. Techniques for determining the proper dose of insulin in a specific situation based on instructions provided by the child's primary care health professional;
d. Techniques for recognizing the symptoms that require administration of glucagon; and
e. Techniques on administering glucagon.

5. States a child care facility may not subject an employee to any penalty or disciplinary action for the employee's refusal to serve as a voluntary diabetes care assistant.

6. Provides if a child care facility follows the policies and procedures adopted by ADHS, the employees and the owner of the child care facility are immune from civil liability with respect to the actions taken to adopt policies and procedures and all decisions made and actions taken that are based on good faith compliance with policies and procedures.

7. Specifies a child care facility and health professionals who provide training for voluntary diabetes care assistants are immune from civil liability for the consequences of the good faith adoption and implementation of policies and procedures.

8. Defines *health professional.*

CURRENT LAW

A.R.S. § 15-344.01 allows a school district governing board or a charter school governing body to adopt policies and procedures for pupils diagnosed with diabetes to manage their diabetes in the classroom, on school grounds and at school sponsored activities. If a school district or charter school follows the policies and procedures adopted, the employees of the school district or charter school and the members of the school district governing board or charter school governing body are immune from civil liability with respect to all actions taken to adopt policies and procedures and all decisions made and actions taken that are based on good faith compliance with policies and procedures.

The school district governing board or the charter school governing body may adopt policies and procedures to designate two or more school employees to serve as voluntary diabetes care assistants. Voluntary care assistants are allowed to administer insulin, assist the pupil with self-administration of insulin, administer glucagon in an emergency situation to a pupil or perform and combination of these actions under specified conditions.

PROPOSED

HOUSE OF REPRESENTATIVES AMENDMENTS TO H.B. 2361

(Reference to printed bill)

Strike everything after the enacting clause and insert:

"Section 1. Title 36, chapter 7.1, article 1, Arizona Revised Statutes, is amended by adding section 36-883.06, to read:

36-883.06. Diabetes management; child care facilities; policies and procedures; civil immunity; definition

A. THE DEPARTMENT MAY ADOPT POLICIES AND PROCEDURES THAT INCLUDE DIABETES MEDICAL MANAGEMENT PLANS FOR CHILDREN WHO HAVE BEEN DIAGNOSED WITH DIABETES BY A HEALTH PROFESSIONAL TO MANAGE DIABETES FOR THOSE CHILDREN ON THE PREMISES OF CHILD CARE FACILITIES AS AUTHORIZED BY A CHILD'S PRIMARY HEALTH PROFESSIONAL. IF THE DEPARTMENT ADOPTS POLICIES AND PROCEDURES PURSUANT TO THIS SUBSECTION, THE POLICIES AND PROCEDURES SHALL AUTHORIZE CHILD CARE FACILITIES TO ADOPT POLICIES AND PROCEDURES TO MANAGE DIABETES FOR CHILDREN WHO ATTEND A CHILD CARE FACILITY AND TO DESIGNATE TWO OR MORE EMPLOYEES OF EACH CHILD CARE FACILITY TO SERVE AS VOLUNTARY DIABETES CARE ASSISTANTS.

B. THE PARENT OR GUARDIAN OF A CHILD WHO HAS BEEN DIAGNOSED WITH DIABETES AND WHO ATTENDS A CHILD CARE FACILITY SHALL HAVE FINAL APPROVAL OF THE CHILD'S VOLUNTARY DIABETES CARE ASSISTANTS. VOLUNTARY DIABETES CARE ASSISTANTS MAY ADMINISTER INSULIN TO A CHILD OR MAY ADMINISTER GLUCAGON TO A CHILD IN AN EMERGENCY SITUATION, OR BOTH, IF ALL OF THE FOLLOWING APPLY:

1. THE VOLUNTARY DIABETES CARE ASSISTANT HAS PROVIDED TO THE CHILD CARE FACILITY A WRITTEN STATEMENT SIGNED BY A HEALTH PROFESSIONAL THAT THE VOLUNTARY DIABETES CARE ASSISTANT HAS RECEIVED TRAINING IN THE ADMINISTRATION OF INSULIN AND GLUCAGON PURSUANT TO SUBSECTION C OF THIS SECTION.

Attachment 21

Adopted ✓ # of Verbals ____
Failed ____ Withdrawn ____
Not Offered ____ Analysts Initials ____

2. A HEALTH PROFESSIONAL IS NOT IMMEDIATELY AVAILABLE TO ATTEND TO THE CHILD AT THE TIME OF THE EMERGENCY.

3. IF THE VOLUNTARY DIABETES CARE ASSISTANT IS AUTHORIZED TO ADMINISTER GLUCAGON, THE CHILD'S PARENT OR GUARDIAN HAS PROVIDED THE CHILD CARE FACILITY WITH AN UNEXPIRED GLUCAGON KIT FOR THE CALENDAR YEAR THAT IS PRESCRIBED FOR THAT CHILD BY A HEALTH PROFESSIONAL.

4. IF THE VOLUNTARY DIABETES CARE ASSISTANT IS AUTHORIZED TO ADMINISTER INSULIN, THE CHILD'S PARENT OR GUARDIAN HAS PROVIDED THE CHILD CARE FACILITY WITH INSULIN AND ALL EQUIPMENT AND SUPPLIES THAT ARE NECESSARY FOR INSULIN ADMINISTRATION.

C. THE TRAINING PROVIDED BY A HEALTH PROFESSIONAL TO VOLUNTARY DIABETES CARE ASSISTANTS SHALL INCLUDE ALL OF THE FOLLOWING:

1. AN OVERVIEW OF ALL TYPES OF DIABETES.

2. THE SYMPTOMS AND TREATMENT OF HYPERGLYCEMIA AND HYPOGLYCEMIA.

3. TECHNIQUES FOR DETERMINING THE PROPER DOSE OF INSULIN IN A SPECIFIC SITUATION BASED ON INSTRUCTIONS PROVIDED BY THE CHILD'S PRIMARY HEALTH PROFESSIONAL.

4. TECHNIQUES FOR RECOGNIZING THE SYMPTOMS THAT REQUIRE THE ADMINISTRATION OF GLUCAGON.

5. TECHNIQUES ON ADMINISTERING GLUCAGON.

D. A CHILD CARE FACILITY MAY NOT SUBJECT AN EMPLOYEE TO ANY PENALTY OR DISCIPLINARY ACTION FOR THE EMPLOYEE'S REFUSAL TO SERVE AS A VOLUNTARY DIABETES CARE ASSISTANT PURSUANT TO THIS SECTION.

E. IF A CHILD CARE FACILITY FOLLOWS THE POLICIES AND PROCEDURES ADOPTED BY THE DEPARTMENT PURSUANT TO SUBSECTION A OF THIS SECTION, THE EMPLOYEES AND THE OWNER OF THE CHILD CARE FACILITY ARE IMMUNE FROM CIVIL LIABILITY WITH RESPECT TO THE ACTIONS TAKEN TO ADOPT POLICIES AND PROCEDURES PURSUANT TO THIS SECTION AND ALL DECISIONS MADE AND ACTIONS TAKEN THAT ARE BASED ON GOOD FAITH COMPLIANCE WITH POLICIES AND PROCEDURES ADOPTED PURSUANT TO THIS SECTION. A CHILD CARE FACILITY AND HEALTH PROFESSIONALS WHO PROVIDE TRAINING FOR VOLUNTARY DIABETES CARE ASSISTANTS PURSUANT TO SUBSECTION C OF THIS SECTION ARE IMMUNE FROM CIVIL LIABILITY FOR THE CONSEQUENCES OF THE GOOD

FAITH ADOPTION AND IMPLEMENTATION OF POLICIES AND PROCEDURES PURSUANT TO THIS SECTION.

F. FOR THE PURPOSES OF THIS SECTION, "HEALTH PROFESSIONAL" MEANS A PERSON WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 13, 14, 17, OR 25 OR A NURSE PRACTITIONER WHO IS LICENSED PURSUANT TO TITLE 32, CHAPTER 15."

Amend title to conform

HEATHER CARTER

2361CARTER
02/12/2016
02:44 PM
C: mjh

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2361

DATE February 16, 2016 MOTION: do pa S/E

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 22

Care of Young Children With Diabetes in the Child Care Setting: A Position Statement of the American Diabetes Association

Linda M. Siminerio,[1] Anastasia Albanese-O'Neill,[2] Jane L. Chiang,[3] Katie Hathaway,[3] Crystal C. Jackson,[3] Jill Weissberg-Benchell,[4] Janel L. Wright,[5] Alan L. Yatvin,[6] and Larry C. Deeb[7]

Diabetes Care 2014;37:2834–2842 | DOI: 10.2337/dc14-1676

POSITION STATEMENT

Diabetes is a relatively common chronic disease of childhood (1); however, capturing prevalence data in children with type 1 and type 2 diabetes has been challenging. The comprehensive SEARCH for Diabetes in Youth (SEARCH) study has made significant strides in better understanding disease prevalence in the pediatric population. A recent SEARCH study found that 1.93 per 1,000 youth (aged <20 years) were diagnosed with type 1 diabetes (2), an increase of 21.1% from 2001 to 2009, with increases seen in all ethnic groups but with non-Hispanic whites disproportionately affected (3). For type 2 diabetes, the SEARCH study reported a prevalence of 0.46 per 1,000 youth (aged 10–20 years), an increase of 30.5% from 2001 to 2009 in all ethnicities (3). As youth rarely die of diabetes, the increase in prevalence is most likely attributed to increased incidence.

An annual increase of 2.3% in type 1 diabetes incidence has been reported in children, with children aged <5 years experiencing the greatest increase relative to all children (4). As type 2 diabetes is rarely seen in children younger than 10 years of age (3), this Position Statement will primarily focus on type 1 diabetes. The primary objective of this Position Statement is to explain that young children (aged ≤5 years) are a vulnerable population and have unique diabetes management needs. Our goal is to describe the diabetes management recommendations in the child care setting. The child care setting includes day care, camp, and other programs where young children with diabetes are enrolled. This Position Statement is meant to guide child care providers in caring for young children with diabetes and is not intended to provide specific advice on the medical management for this population. While Position Statements contain evidence-based recommendations, all of the information that pertains to young children is expert opinion only. For more detailed information on the medical management of type 1 diabetes in children, please refer to the American Diabetes Association's (ADA's) "Standards of Medical Care in Diabetes—2014" (5) and "Type 1 Diabetes Through the Life Span: A Position Statement of the American Diabetes Association" (6).

UNIQUE CHALLENGES FOR THE YOUNG CHILD

Infants, toddlers, and preschool-age children (≤5 years of age) are enrolled in the more than 330,000 child care programs across the country (7). These children wholly depend on adults for most, if not all, aspects of their care. Pediatric health care providers, parents/guardians, and child care staff must work together to ensure that young children with diabetes are provided with the safest possible child care environment. This collaboration is essential to achieve a seamless transition in care from home to the child care setting.

Managing type 1 diabetes in young children in child care programs presents unique challenges due to the young child's developmental level. The limited communication and motor skills, cognitive abilities, and emotional maturity of young children can challenge even the most experienced child care provider. For example, young children with hypo- or hyperglycemia may or may not exhibit abnormal behavior or irritability. As erratic behavior is typical in this age-group, the child care provider may not recognize hypo- or hyperglycemic symptoms and may miss

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This Position Statement was reviewed and approved by the Professional Practice Committee in July 2014 and approved by the Executive Committee of the Board of Directors in July 2014.

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Attachment 23

the fact that the behavior is caused by low or high blood glucose levels that may require treatment.

The diabetes regimen must be adapted quickly to the child's dynamic growth and development. As the child develops and desires greater autonomy, child care providers and parents/guardians may face challenges with the toddler's refusal to cooperate with his or her diabetes care regimen (8). Once the child enters the prekindergarten years, he or she may begin to be able to participate in his or her own care by indicating food preferences, checking blood glucose, and choosing a finger-prick or injection site. With further cognitive and physical development, he or she may verbalize symptoms and become more cooperative, but the child still needs constant supervision and blood glucose monitoring to detect hypo- or hyperglycemia. The age at which children are able to perform self-care tasks is variable and depends on the individual child's capabilities, but self-care is not expected from the young child and the parent/guardian or other caregiver *must* provide diabetes management and perform associated diabetes care tasks such as blood glucose monitoring and insulin administration (5,8) (Table 1).

Language barriers, ethnic and cultural practices, limited resources and support, geography (rural vs. urban setting), and health literacy and capabilities must also be considered in developing the care plan.

Another challenge in the child care setting may be staff turnover and ensuring that trained staff members remain available. Regardless, the child care program must be prepared to provide needed care to the child, and parents and health care providers play a pivotal role in partnering with the child care staff.

Key Points

- The safety, health, and well-being of the child as he or she transitions from home to the child care setting are achieved through effective collaboration between the diabetes health care provider, parents/guardians, and child care staff.
- Adults must provide most, if not all, of the diabetes care to young children because of their limited motor, cognitive, and communication skills as well as other abilities that are necessary to participate in self-management.
- As the child grows older and becomes closer to school age, he or she may participate in care tasks as appropriate for the individual child, but adult supervision must always be present.
- Challenges in the child care setting include staff turnover, language barriers, ethnic and cultural practices, limited resources and support, geography (rural vs. urban setting), and health literacy and capabilities.

DIABETES CARE

The Diabetes Control and Complications Trial (DCCT) showed a significant link between blood glucose control and a slower onset and progression of diabetes complications in adults and adolescents, with improved glycemic control decreasing the risk of micro- and macrovascular complications (5,9,10). Although the DCCT did not include young children (the lower age limit at enrollment was 13 years), the general message—optimize blood glucose control while avoiding hypoglycemia—has been clinically applied to young children. Furthermore, recent data from cross-sectional neuroimaging studies in young children appear to reinforce the importance of aiming for blood glucose levels in range and avoiding hypo- and hyperglycemia (11).

Nutrition and Physical Activities

The parent/guardian remains primarily responsible for determining and providing healthy food choices for the child. The parent/guardian should educate the staff on general information on the carbohydrate content of the food, regardless of whether it is provided by the parent/guardian or child care program. If a child care program provides the meals and snacks, the parent/guardian and the child care provider should work together to determine appropriate food choices and portion sizes for the child. The child care program should ensure that the child eats the appropriate amount of food that is being covered by insulin in accordance with the diabetes medical management plan (DMMP). See the section on DMMP for further details.

For children who regularly attend child care programs for longer durations or where meals or snacks and physical activity are part of the daily schedule, sufficient staff should receive comprehensive training in diabetes management and be prepared to provide diabetes care as needed. At least one staff member should be available at all times to help with food decisions, blood glucose monitoring, and insulin administration.

Increased sensitivity in caring for the child around special occasions (such as parties/celebrations), physical activities, or illnesses is particularly important. The child should be allowed to participate in celebrations, but special considerations may be required to accommodate the child's diabetes needs. Effective communication between the child care staff and the parent/guardian to anticipate the adjustments (e.g., administering additional insulin to account for the birthday cake) will enable the young child to feel included. Resources are available to parents/guardians, child care providers, and health care providers to assist with this education and training (12–15).

Children who participate in programs for only a few hours may consume snacks and not meals; therefore, insulin administration may not be required in the child's DMMP. However, at a minimum, in order to facilitate safe diabetes care in all child care programs, child care staff must have a basic understanding of diabetes; be able to check blood glucose levels; be able to prevent, recognize, and treat hypoglycemia; be able to handle diabetes emergencies; and know who to contact for help (12–14,16).

Hypoglycemia

For the very young child, the diabetes management priority is the prevention and management of hypoglycemia and the avoidance of wide fluctuations in blood glucose levels. Parents/guardians face the perpetual struggle of balancing the risk of long-term complications from hyperglycemia with the fear of acute hypoglycemia, all while trying to facilitate a "normal" childhood. More notably, parents worry about the possibility of cognitive deficits and/or death if a severe hypoglycemic event is undetected and untreated. Therefore, hypoglycemia prevention is critical. Child care staff should be educated on how to prevent and recognize hypoglycemia by monitoring the child's food consumption, activity, and behavior and confirming a suspected low with blood glucose monitoring (5,8,17). Parents/guardians should provide specific

Table 1—Major developmental issues and their effect on diabetes in children and adolescents

Developmental stages (ages)	Normal developmental tasks	Type 1 diabetes management priorities	Family issues in type 1 diabetes management
Infancy (0–12 months)	Developing a trusting relationship or bond with primary caregiver(s)	Preventing and treating hypoglycemia Avoiding extreme fluctuations in blood glucose levels	Coping with stress Sharing the burden of care to avoid parent burnout
Toddler (13–26 months)	Developing a sense of mastery and autonomy	Preventing hypoglycemia Avoiding extreme fluctuations in blood glucose levels due to irregular food intake	Establishing a schedule Managing the picky eater Limit-setting and coping with toddler's lack of cooperation with regimen Sharing the burden of care
Preschooler and early elementary school (3–7 years)	Developing initiative in activities and confidence in self	Preventing hypoglycemia Coping with unpredictable appetite and activity Positively reinforcing cooperation with regimen Trusting other caregivers with diabetes management	Reassuring the child that diabetes is no one's fault Educating other caregivers about diabetes management
Older elementary school (8–11 years)	Developing skills in athletic, cognitive, artistic, and social areas Consolidating self-esteem with respect to the peer group	Making diabetes regimen flexible to allow for participation in school or peer activities Child learning short- and long-term benefits of optimal control	Maintaining parental involvement in insulin and blood glucose management tasks while allowing for independent self-care for special occasions Continuing to educate school and other caregivers
Early adolescence (12–15 years)	Managing body changes Developing a strong sense of self-identity	Increasing insulin requirements during puberty Diabetes management and blood glucose control becoming more difficult Weight and body image concerns	Renegotiating parent and teenager's roles in diabetes management to be acceptable to both Learning coping skills to enhance ability to self-manage Preventing and intervening in diabetes-related family conflict Monitoring for signs of depression, eating disorders, and risky behaviors
Later adolescence (16–19 years)	Establishing a sense of identity after high school (decisions about location, social issues, work, and education)	Starting an ongoing discussion of transition to a new diabetes team (discussion may begin in earlier adolescent years) Integrating diabetes into new lifestyle	Supporting the transition to independence Learning coping skills to enhance ability to self-manage Preventing and intervening with diabetes-related family conflict Monitoring for signs of depression, eating disorders, and risky behaviors

strategies, if needed, to help the child care staff address the individual child's specific needs. Routine blood glucose monitoring at prespecified times may help to detect hypoglycemia before it manifests with acute symptoms in the child.

Hyperglycemia

Although hypoglycemia is a significant concern, hyperglycemia should be managed as well. The child may experience frequent urination (polyuria), which may be confused with "heavy diapers" or "wetting accidents," a common occurrence in this age-group anyway. A child care provider unfamiliar with diabetes and polyuria may not realize that the child is hyperglycemic, requiring insulin, and instead may feed the child or give him or her juice, inadvertently aggravating hyperglycemia. Untreated hyperglycemia may lead to ketone production, which may be measured by checking urine ketones.

The ADA has previously recommended higher blood glucose targets for young children in an effort to prevent hypoglycemia. However, the **ADA has recently adjusted its target recommendations to an A1C of <7.5% in all pediatric age-groups (<19 years of age) but with the goal of achieving the best A1C possible without hypoglycemia**. The new recommendation is a product of reduced hypoglycemia seen with newer rapid-acting insulin analogs and improved glucose monitoring devices and the awareness of the potential impact of chronic hyperglycemia on the development of future long-term complications (6).

Blood Glucose Monitoring

Blood glucose monitoring allows child care providers to assess if a child is hypo- or hyperglycemic and perform appropriate interventions. Blood glucose levels need to be checked before meals/snacks, before physical activity, and when the child exhibits symptoms of hypo- or hyperglycemia. These symptoms may be subtle, especially in young children. For this reason, blood glucose needs to be checked more frequently in young children.

Continuous Glucose Monitors

Some children use a continuous glucose monitor (CGM) to record blood glucose levels. CGM results must be confirmed with blood glucose tests. Parents/guardians should discuss CGM management with child care providers. A basic understanding of CGM use is warranted, but detailed management should not be expected of child care providers. Safe monitoring must include the following recommendations:

1. Avoid community exposure to sharps and other medical waste.
2. Minimize trauma to the finger or relevant lancing site.

Blood lancing devices must not be reused, point-of-care devices should only be used for the designated child, and child care providers should use gloves when testing (8). The ADA's Safe at School program is a helpful resource to assist schools (18).

Insulin Administration

Children with diabetes who attend child care programs must have access to insulin, glucagon, and other medications to safely participate in the programs. Training child care staff on insulin administration is a critical component of diabetes management, especially for those caring for children who participate in daylong (4- to 8-h) programs and who will likely need insulin administered during the programs. For resources, please see RESOURCES for ADA's Safe at School program.

Glucagon

Glucagon may be indicated if a child has severe hypoglycemia and is unable to consume glucose or is having a hypoglycemic seizure. Although a glucagon kit requires a prescription, any individual may administer glucagon. Child care staff should be trained in the administration of glucagon or, if indicated, mini-dose glucagon (19). It is also important to ensure that the glucagon kits are not expired (5).

Key Points

- The DCCT showed that improved glycemic control decreases long-term diabetes complications in adolescents (≥13 years of age) and adults and helped establish intensive therapy as the standard of care. Although young children were not included in the study, the same principles apply to this age-group.
- Regardless of the amount of time the child spends in the child care setting, staff should monitor carbohydrate intake and understand the impact of carbohydrates and physical activity as set out in the child's DMMP.
- Trained child care staff should be available to meet the child's basic diabetes needs, including the recognition and treatment of hypo- and hyperglycemia, blood glucose monitoring, and insulin and glucagon administration.
- Diabetes management requirements may vary depending on the length, frequency, and activities of the child care program.
- The key diabetes management priority for younger children is the prevention, recognition, and treatment of hypo- and hyperglycemia to keep the child safe and healthy.

DMMP

The child's written care plan, such as the DMMP, facilitates appropriate diabetes management and is essential to achieving optimal glycemic control. The DMMP contains the medical orders that are the basis for the provision of care in the child care setting and is the child's individual care plan. It is developed by the child's own diabetes health care provider with input from the parent/guardian. A sample DMMP for the child care setting may be found at the end of this document or at www.diabetes.org/childcare. The DMMP should address the specific needs of the child and provide instructions for each of the following:

1. Blood glucose monitoring, including the frequency and circumstances requiring blood glucose checks and the use of CGM systems;
2. Insulin administration including doses and administration times prescribed for specific blood glucose levels and for carbohydrate intake, the storage of insulin, and the use of the prescribed insulin delivery device, including syringe, pen, or pump;
3. Symptoms and treatment of hypoglycemia, including the administration of glucagon;
4. Symptoms and treatment of hyperglycemia, including insulin administration;
5. Urine or blood ketone checks and appropriate actions based on a child's ketone level.

The child care program needs to coordinate and arrange diabetes education provided by a diabetes health care professional and/or the parent/guardian at an appropriate level and with proper considerations for the child care staff. All staff members responsible for the child should have a basic knowledge of the child's diabetes, understand basic diabetes management, and know who to contact for help. Designated staff members who will be performing diabetes care tasks need advanced diabetes education that includes blood glucose monitoring, insulin and glucagon administration, monitoring of carbohydrate intake and physical activity, and recognizing and treating hyperglycemia (monitoring for excessive urination or thirst, allowing bathroom privileges, and administering insulin) and hypoglycemia (monitoring for sleepiness, lethargy, shakiness, or other symptoms and providing appropriate carbohydrate sources even if outside the allotted snack or meal time frames). Emergency treatment, including glucagon administration, should also be taught with clear instructions for the next steps if the interventions are unsuccessful (Table 2).

LAWS PROTECTING CHILDREN WITH DIABETES

Federal antidiscrimination laws, including the Americans with Disabilities Act (20) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (21), prohibit discrimination on the basis of disability. The Individuals with Disabilities Education Act (IDEA) requires prekindergarten programs to identify children with disabilities and to provide them with a free and appropriate education (22).

The Americans with Disabilities Act prohibits discrimination against people with disabilities by places of public accommodation, including camps and child care programs. This includes even a home-based setting, if the program is open to the public. Programs operated by religious organizations, such as a child care program run by a church, are not subject to the nondiscrimination obligations under federal law unless the program receives federal funds. Child care providers with obligations under the Americans with Disabilities Act must make reasonable

Table 2—Diabetes care tasks prescribed by DMMP to be provided by child care staff

Task	Frequency	Equipment/supplies (provided by parent/guardian)
Blood glucose monitoring	Before food intake and physical activity and when low or high blood glucose is suspected	Blood glucose meter, lancet, lancing device, test strips, CGM*
Insulin administration	Before or after food intake and to treat high blood glucose	Insulin, delivery device (pump, pen, syringe)
Food intake scheduling and monitoring	Snacks and meals provided and/or monitored to ensure food consumption is in accordance with insulin dosing	Food, carbohydrate information
Hypoglycemia treatment	Awareness that unusual behaviors after physical activity or insulin administration may signify hypoglycemia	Quick-acting carbohydrate and glucagon
Hyperglycemia treatment	Awareness that increased urination or drinking may signify hyperglycemia	Noncarbohydrate-containing liquid, insulin
Ketone monitoring	Check ketones if repeated blood glucose tests show elevation above target range or if the child is ill	Urine or blood ketone strips, ketone monitor

*This device may or may not be used by the child.

modifications to their policies and practices to enable a child with a disability, such as diabetes, to fully participate in the program unless the modifications impose an "undue hardship" or cause a "fundamental alteration" to the nature of the program (20,21,23). The child care program must conduct an individual assessment to determine whether or not it can meet the child's needs without imposing undue hardship or fundamentally altering the program.

Section 504 prohibits discrimination on the basis of disability by any entity receiving federal funds—including religious organizations. Types of programs covered by Section 504 might include after-school child care programs offered by a public school system and child care programs run by universities. The obligations of a child care program subject to Section 504 are very similar to those obligations under the Americans with Disabilities Act, including a requirement to conduct an individualized assessment of a child's needs. Both the Americans with Disabilities Act and Section 504 require programs to provide disability-related accommodations if they are necessary and reasonable. Many of the needed accommodations can be provided by the child care program without significant costs. Some accommodations that may be needed include having a trained employee who can perform blood glucose checks, administer insulin and glucagon, recognize and promptly treat hypo- and hyperglycemia, and make sure the child consumes needed carbohydrates.

In addition, many states have laws that impact the provision of diabetes care in the child care setting. Even though federal laws provide protection for children with disabilities, such as diabetes, state laws, regulations, or policies and guidelines often affect whether nonnursing staff in the child care setting can administer medication, including insulin and glucagon, to a child with diabetes. Some states have specific child care rules that place requirements on child care programs to provide care to children with chronic illness, specify how staff must be trained, or specify whether and how medication may be administered to children. State laws cannot, however, lessen a child care program's obligations under federal law.

Children with diabetes in child care programs still face discrimination despite the protections and requirements of federal and state laws. For example, some child care programs refuse to enroll a child with diabetes, and some programs refuse to allow a newly diagnosed child back into the program. Some centers will enroll a child only if the parent/guardian agrees to come to the center to provide needed care. Many other programs have "no injection" or "no medication" policies that do not consider the individual child's needs. This type of treatment jeopardizes the health and safety of the child, and such blanket policies are unlawful. For more information and resources to help with diabetes management in the child care setting or if a child is experiencing discrimination in the child care setting, call 1-800-DIABETES (342-2382) or go to www.diabetes.org/childcare.

Key Points

- Federal and some state laws provide protections for children with diabetes in the child care setting.
- Despite federal and state laws, children in child care programs still face discrimination, jeopardizing their health and safety or making it difficult for them to enroll in child care.

KEY PRINCIPLES

Here, we reiterate the discussed concepts; however, the section is structured so that it outlines the legal principles and the roles and responsibilities of the individuals involved.

1. **Acceptance for enrollment.** Child care programs should not deny admission to a child based on diabetes or the need for diabetes care. The parent/guardian should share strategies for overcoming challenges specific to their child, such as poor communication or resistance to diabetes care tasks. If a child care center refuses to enroll or provide diabetes care to a child, it is important to determine the center's concerns and see if the concerns can be addressed through education and training.
2. **Written care plans.** As stated previously, a written care plan, such as an individualized DMMP, should be developed by the child's personal diabetes health care team in collaboration with the parent/guardian.
3. **Provision of care by child care staff.** After consulting with the parent/guardian and reviewing the child's

current DMMP, the child care program should perform an assessment of the child's needs to determine how it will provide diabetes care. An identified group of child care staff who are willing to provide direct care for the child with diabetes should receive advanced training from a diabetes health care professional or the parent/guardian on routine and emergency diabetes care so that at least one staff member is always available to provide diabetes care.

4. **Basic training for all staff in a child care setting.** The child care provider should work with the parents/guardians to arrange for training by a diabetes health care professional or the parent/guardian in basic diabetes education and identify additional training resources as needed. All child care staff members who are responsible for the child with diabetes should receive basic training that provides:
   1) An overview of diabetes that includes information on how to recognize and respond to hypo- and hyperglycemia and
   2) Instruction on identifying medical emergencies and contacting the right personnel with questions or in case of an emergency.
5. **Advanced training for a small group of child care staff.** Advanced training provided by a diabetes health care professional or parent/guardian should include:
   1) All components of basic diabetes training as listed above;
   2) Instruction on how to perform blood glucose monitoring, insulin and glucagon administration, and urine and/or blood ketone checks;
   3) Training on the recognition and treatment of hypo- and hyperglycemia; and
   4) Basic carbohydrate counting/monitoring carbohydrates.
6. **Instruction should include demonstration of the care tasks and a plan for ongoing training.** The number of staff members trained should be sufficient to ensure that at least one staff member who can provide routine and emergency diabetes care, such as insulin and glucagon administration, will be available at all times.
7. **Participation in diabetes care should be allowed for capable children.** Child care programs should support the child in his or her development by allowing participation in diabetes tasks in accordance with the child's competencies, as outlined in the DMMP. A preschooler may be able to participate in his or her diabetes care by checking blood glucose or choosing a fingerprick or injection site, all under the supervision of an adult.

Key Points

- Child care centers should not deny admission on the basis of a child having diabetes.
- A written care plan with medical orders, such as a DMMP, should be provided by the diabetes care provider and parent/guardian to the child care setting.
- All child care staff responsible for the child with diabetes should receive basic training.
- Advanced, child-specific training should be provided to a small number of child care staff, and there should be at least one trained staff member available to provide care at all times.

RESPONSIBILITIES OF STAKEHOLDERS

1. **The parent/guardian should provide the child care program with:**
   - Information about diabetes management and training resources if needed
   - A completed written care plan, such as a DMMP, signed by a child's diabetes health care provider
   - Current and accurate emergency contact information including phone numbers for the parent/guardian and the child's diabetes health care provider
   - All materials, equipment, supplies, insulin/medication, and food needed for diabetes management and ongoing monitoring of supplies for replenishment or replacement if expired
   - An appropriate container for the disposal of sharps
   - A method of communication between the parent/guardian and the child care program, such as a logbook or electronic diabetes management application
   - Basic diabetes training (if needed) for all child care staff members who have responsibility for the child and advanced child-specific training for the designated child care staff members who are responsible for providing regular daily care to the child
   - Information about factors that may impact blood glucose levels, such as the child's daily activity level, food intake prior to arrival at the center, and whether the child is experiencing an illness
   - Consent to release confidential health information so that the child care program can communicate directly with the child's diabetes health care provider and direction on when such communication is appropriate
2. **The child care program should:**
   - Understand federal and state laws and regulations as they apply to children with diabetes
   - Assess how the child care program will provide routine and emergency care after consulting with parent/guardian and reviewing the DMMP
   - Recruit and designate staff who will be responsible for the provision of diabetes care to the child
   - Work with parents/guardians to arrange for training for all staff members who have responsibility for the child and advanced child-specific training for designated child care staff members who are responsible for providing daily care to the child
   - Provide secure and immediate accessibility of diabetes materials, equipment, supplies, insulin/medication, and food to trained staff members
   - Provide support to all families of children in its care who are faced with language barriers and limited resources and be aware of and share community resources for families of children with diabetes
   - Maintain accurate documentation of all diabetes care provided to a child in its care
   - Collaborate with parents/guardians and/or diabetes health care providers to obtain current information about the care of children with diabetes

- Regularly communicate blood glucose results, insulin administration, treatment of hypo- and hyperglycemia, food intake, and physical activity using a logbook, electronic application, or other method provided by the parent/guardian
- Treat children with diabetes the same as other children, except to meet their diabetes needs
- Respect the child's and family's confidentiality and right to privacy

3. **The child's diabetes health care provider should provide:**
   - A completed and signed written care plan containing medical orders, such as a DMMP, with updates as needed
   - In conjunction with the parent/guardian, basic and advanced training to child care staff
   - Availability to respond to questions about the child's care with parental consent
   - Ongoing diabetes expertise and guidance as needed
   - Advocacy, as needed, to ensure a child's needs are met while in the child care setting

Key Points

- Parents/guardians, child care staff, and the child's health care provider all play important roles in ensuring appropriate care of the child with diabetes in a child care program. Each has specific roles and responsibilities to ensure that the child is maintained in a healthy and safe child care environment.

CONCLUSION

It is well understood that young children with diabetes have unique needs. Young children require a carefully thought-out, proactive diabetes care plan and not a reactive one (i.e., crisis management) that must be developed with the health care provider, parents/guardians, and child care staff. Unfortunately, despite all the best efforts of the parents/guardians, care may be suboptimal in the child care setting. For those instances, there are federal laws that protect the rights of the young child. Violation of these rights may be subject to legal action. Recommended resources for parents are listed below. We encourage parents/guardians of young children with diabetes to share this Position Statement with their child care providers. Ensuring the long-term health of and providing the best care to these young children should be of paramount importance.

RESOURCES

- American Diabetes Association. Child Care Setting tools (including Child Care DMMP): www.diabetes.org/childcare and www.diabetes.org/forparentsandkids.
- American Diabetes Association. Safe at School resources and information: www.diabetes.org/safeatschool.
- American Diabetes Association. Diabetes Care Tasks at School: What Key Personnel Need to Know: www.diabetes.org/schooltraining.
- National Diabetes Education Program. Helping the Student with Diabetes Succeed: A Guide for School Personnel (2010): http://ndep.nih.gov/media/Youth_NDEPSchoolGuide.pdf.

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Child Care Diabetes Medical Management Plan

American Diabetes Association.
YOUR RIGHTS. ONE VOICE.™

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or Guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature: _____ Date: _____

Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: ☐ 80-180 ☐ Other _____

When to check blood glucose: ☐ before breakfast ☐ before lunch ☐ before dinner ☐ before snacks

When to do extra blood glucose checks: ☐ before exercise ☐ after exercise ☐ when showing signs of low blood glucose ☐ when showing signs of high blood glucose ☐ other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

☐ Insulin Pump ☐ Multiple Daily Injections ☐ Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): ☐ Regular ☐ Apidra ☐ Humalog ☐ Novolog ☐ NPH ☐ Lantus ☐ Levemir ☐ Mix ☐ Other _____

Plan A: Insulin Pump*

1. Always use the insulin pump bolus wizard: ☐ Yes ☐ No
   If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
2. Blood glucose must be checked before the child eats and will (check one):
   ☐ Be sent to the pump by the meter
   ☐ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
4. **After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

1. Child will receive a fixed dose of _____ long-acting insulin at _____ ☐ **Yes** ☐ **No**
2. Follow blood glucose monitoring plan above.
3. **Use _____ insulin for meals and snacks. Insulin dose for food is** _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.

Give injection after the child eats.

4. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or this scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

1. Child will receive a fixed dose of long-acting insulin? ☐ **Yes** ☐ **No**
   If yes, give child _____ units of _____ insulin at _____.
2. Insulin correction dose at child care (_____ insulin)?
   ☐ Yes ☐ No
3. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or the following scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast-acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast-acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15 grams of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

☐ Shaky ☐ Fast heartbeat ☐ Sweating
☐ Anxious ☐ Hungry ☐ Weakness/Fatigue
☐ Headache ☐ Blurry vision ☐ Irritable/Grouchy
☐ Dizzy ☐ Other _____

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
   - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardians. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

☐ Extreme thirst ☐ Very wet diapers, accidents
☐ Hungry ☐ Warm, dry, flushed skin ☐ Tired or drowsy
☐ Headache ☐ Blurry vision ☐ Vomiting**
☐ Fruity breath ☐ Rapid, shallow breathing
☐ Abdominal pain ☐ Unsteady walk (more than typical)

**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
   ☐ urine ☐ blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parent if ketones are trace or small: ☐ Yes ☐ No
3. Children with high blood glucose will require additional insulin if **the last dose of insulin was given 3 or more hours earlier.** Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar-free fluids as tolerated.
5. You may also:
   ☐ Provide carbohydrate-free snacks if hungry
   ☐ Delay exercise
   ☐ Change diapers frequently/give frequent access to the bathroom
   ☐ Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction factor – The drop in blood glucose level, measured in milligrams per deciliter (mg/dL), caused by each unit of insulin taken. Also called **insulin sensitivity factor.**

Diabetic ketoacidosis (DKA) – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed-dose regimen – Children with diabetes who use a fixed-dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct **hyperglycemia.**

Glucagon – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using an insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA).**

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple daily injection regimen - Multiple daily insulin regimens typically include a basal, or long-acting, insulin given once per day. A short-acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

_____
Physician Signature

Safe at School

Child Care Diabetes Medical Management Plan

American Diabetes Association.
YOUR RIGHTS. ONE VOICE.™

Name of Child: _____ DOB: _____ Dates Plan in Effect: _____

Parent or guardian Name(s)/Number(s): _____

Diabetes Care Provider Name/Number: _____

Diabetes Care Provider Signature: _____ Date: _____

Location of diabetes supplies at child care facility: _____

Blood Glucose Monitoring

Target range for blood glucose is: ☐ 80-180 ☐ Other _____

When to check blood glucose: ☐ before breakfast ☐ before lunch ☐ before dinner ☐ before snacks

When to do extra blood glucose checks: ☐ before exercise ☐ after exercise ☐ when showing signs of low blood glucose ☐ when showing signs of high blood glucose ☐ other _____

Insulin Plan: Please indicate which type of insulin regimen this child uses (check one):

☐ Insulin Pump ☐ Multiple Daily Injections ☐ Fixed Insulin Doses

Specific information related to each insulin regimen/plan is included below for this child.

Type of insulin used at child care (check all that apply): ☐ Regular ☐ Apidra ☐ Humalog ☐ Novolog ☐ NPH ☐ Lantus ☐ Levemir ☐ Mix ☐ Other _____

Plan A: Insulin Pump*

1. Always use the insulin pump bolus wizard: ☐ Yes ☐ No
   If no, use Insulin:Carbohydrate Ratio and Correction Factor dosage on Plan B.
2. Blood glucose must be checked before the child eats and will (check one):
   ☐ Be sent to the pump by the meter
   ☐ Need to be entered into the pump
3. The insulin pump will calculate the correction dose to be delivered **before** the meal/snack.
4. **After the meal/snack**, enter the total number of carbohydrates eaten at that meal/snack. The insulin pump will calculate the insulin dose for the meal.
5. Contact parent/guardian with any concerns.

For a list of definitions of terms used in this document, please see the *Diabetes Dictionary*.

***Providers should complete Insulin:Carbohydrate ratio and Correction dosage under Plan B section for ALL pump users.**

Plan B: Multiple Daily Injections

1. Child will receive a fixed dose of _____ long-acting insulin at _____ ☐ **Yes** ☐ **No**
2. Follow blood glucose monitoring plan above.
3. **Use** _____ **insulin for meals and snacks. Insulin dose for food is** _____ unit(s) for meals **OR** _____ unit(s) for every _____ grams carbohydrate.

Give injection after the child eats.

4. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or this scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

C: Fixed Insulin Doses

1. Child will receive a fixed dose of long acting insulin? ☐ **Yes** ☐ **No**
   If yes, give child _____ units of _____ insulin at _____.
2. Insulin correction dose at child care (_____ insulin)?
   ☐ Yes ☐ No
3. If blood glucose is above target, add correction dose to:
   ☐ **Breakfast** ☐ **Snack**
   ☐ **Lunch** ☐ **Snack**
   ☐ **Other:** _____

Use the following correction factor _____ or the following scale:

_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____
_____ units if BG is _____ to _____

Only add correction dose if it has been 3 hours since the last insulin administration.

Managing Very Low Blood Glucose

Hypoglycemia Plan for Blood Glucose less than _____ mg/dL

1. Give 15 grams of fast acting carbohydrate.
2. Recheck blood glucose in 15 minutes.
3. If still below 70 mg/dL, offer 15 grams of fast acting carbohydrate, check again in 15 minutes.
4. When the child's blood glucose is over 70, provide 15g of carbohydrate as snack. Do not give insulin with this snack.
5. **Contact the parent/guardian** any time blood glucose is less than _____ mg/dL at child care.

Usual symptoms of hypoglycemia for this child include:

☐ Shaky ☐ Fast heartbeat ☐ Sweating
☐ Anxious ☐ Hungry ☐ Weakness/Fatigue
☐ Headache ☐ Blurry vision ☐ Irritable/Grouchy
☐ Dizzy ☐ Other _____

1. If you suspect low blood glucose, check blood glucose!
2. If blood glucose is below _____, follow the plan above.
3. If the child is unconscious, having a seizure (convulsion) or unable to swallow:
   - Give glucagon. Mix liquid and powder and draw up to the first hash mark on the syringe. Then inject into the thigh. Turn child on side as vomiting may occur.
   - If glucagon is required, administer it promptly. Then, call 911 (or other emergency assistance). After calling 911, contact the parents/guardian. If unable to reach parent, contact diabetes care provider.

Managing Very High Blood Glucose

Hyperglycemia Plan for Blood Glucose higher than _____ mg/dL

Usual symptoms of hyperglycemia for this child include:

☐ Extreme thirst ☐ Very wet diapers, accidents
☐ Hungry ☐ Warm, dry, flushed skin ☐ Tired or drowsy
☐ Headache ☐ Blurry vision ☐ Vomiting**
☐ Fruity breath ☐ Rapid, shallow breathing
☐ Abdominal pain ☐ Unsteady walk (more than typical)
**If child is vomiting, contact parents immediately

Treatment of hyperglycemia/very high blood glucose:

1. Check for ketones in the:
   ☐ urine ☐ blood (parent will provide training)
2. **If ketones are moderate or large**, contact parent. If unable to reach parent, contact diabetes care provider for additional instructions.
   Contact parent if ketones are trace or small: ☐ Yes ☐ No
3. Children with high blood glucose will require additional insulin **if the last dose of insulin was given 3 or more hours earlier**. Consult the insulin plan above for instructions. If still uncertain how to manage high blood glucose, contact the parent.
4. Provide sugar free fluids as tolerated.
5. You may also:
   ☐ Provide carbohydrate free snacks if hungry
   ☐ Delay exercise
   ☐ Change diapers frequently/give frequent access to the bathroom
   ☐ Stay with the child

Diabetes Dictionary

Blood glucose - The main sugar found in the blood and the body's main source of energy. Also called blood sugar. The **blood glucose level** is the amount of glucose in a given amount of blood. It is noted in milligrams in a deciliter, or mg/dL.

Bolus - An extra amount of insulin taken to lower the blood glucose or cover a meal or snack.

Bolus calculator – A feature of the insulin pump that uses input from a pump user to calculate the insulin dose. The user inputs the blood glucose and amount of carbohydrate to be consumed, and the pump calculates the dose that can be approved by the user.

Correction Factor – The drop in blood glucose level, measured in milligrams per deciliter (mg/dl), caused by each unit of insulin taken. Also called **insulin sensitivity factor.**

Diabetic Ketoacidosis (DKA) – An emergency condition caused by a severe lack of insulin, that results in the breakdown of body fat for energy and an accumulation of ketones in the blood and urine. Signs of DKA are nausea and vomiting, stomach pain, fruity breath odor and rapid breathing. Untreated DKA can lead to coma and death.

Fixed dose regimen – Children with diabetes who use a fixed dose regimen take the same "fixed" doses of insulin at specific times each day. They may also take additional insulin to correct **hyperglycemia.**

Glucagon – A hormone produced in the pancreas that raises blood glucose. An injectable form of glucagon, available by prescription, is used to treat severe hypoglycemia or severely low blood glucose.

Hyperglycemia - Excessive blood glucose, greater than 240 mg/dL for children using and insulin pump and greater than 300 mg/dL for children on insulin injections. If untreated, the patient is at risk for **diabetic ketoacidosis (DKA).**

Hypoglycemia - A condition that occurs when the blood glucose is lower than normal, usually less than 70 mg/dL. Signs include hunger, nervousness, shakiness, perspiration, dizziness or light-headedness, sleepiness, and confusion. If left untreated, hypoglycemia may lead to unconsciousness.

Insulin - A hormone that helps the body use glucose for energy. The beta cells of the pancreas make insulin. When the body cannot make enough insulin, it is taken by injection or through use of an insulin pump.

Insulin Pump - An insulin-delivering device about the size of a deck of cards that can be worn on a belt or kept in a pocket. An insulin pump connects to narrow, flexible plastic tubing that ends with a needle inserted just under the skin. Pump users program the pump to give a steady trickle or constant (basal) amount of insulin continuously throughout the day. Then, users set the pump to release bolus doses of insulin at meals and at times when blood glucose is expected to be higher. This is based on programming done by the user.

Ketones - A chemical produced when there is a shortage of insulin in the blood and the body breaks down body fat for energy. High levels of ketones can lead to **diabetic ketoacidosis** and coma.

Multiple Daily Injection Regimen - Multiple daily insulin regimens typically include a basal, or long acting, insulin given once per day. A short acting insulin is given by injection with meals and to correct hyperglycemia, or elevated blood glucose, multiple times each day.

Type 1 Diabetes - Occurs when the body's immune system attacks the insulin-producing beta cells in the pancreas and destroys them. The pancreas then produces little or no insulin. Type 1 diabetes develops most often in young people but can appear in adults. It is one of the most common chronic diseases diagnosed in childhood.

_____
Physician Signature

Safe at School®

Carter was diagnosed with Type 1 Diabetes (in DKA when diagnosed) on May 1, 5 days after his 5th birthday.

We had taken him to urgent care on Wednesday and they said that he had tonsillitis. He was prescribed an antibiotic and sent home. After 2 days of antibiotics he was worse and I knew something was not right. We went to his pediatrician.

The pediatrician was not sure what was wrong and ordered blood work. He left the room to get the papers and came back. He explained that he did not feel good waiting as we were headed into the weekend. He sent us to Cardon Children's Hospital.

The admitting nurse at the ER recorded his symptoms and asked if his blood had been checked. My confusion set in, for what? His blood sugar was checked and came back with a reading of "HIGH", meaning over 600. He was immediately taken back to the ER and and IV tried to get started. He was so dehydrated that it took 8 pokes to finally get an IV in; it was put in his carotid artery in his neck. He spent 3 days in the PICU at Cardon Children's Hospital.

Carter had been attending CLA (Children's Learning Adventure - at Crismon and Baseline in Mesa). I called them to see what we needed to do to ensure his safety. The director called back and advised me that he could continue attending however they could not or would not do anything with needles. I asked if it was a training issue and that we could supply proper training for the staff. I was told that I would have to be present for all blood checks and shots. This was not an option due to my work. Additionally, T1D is not a scheduled condition. The need for checks can occur at any time. Without staying at the school with him, I had no way to make this happen. I had no other option, he had to be disenrolled from CLA.

So much had changed for this poor little guy, so quickly. This part would be the worst of his diagnosis. He cried every day, saying that he just wanted to see his friends. He had been with some of these classmates for over 2 years. He hated that he had T1D because to him, it took away his friends.

HOUSE OF REPRESENTATIVES

HB 2667

dental care; treatment; volunteer care
Prime Sponsor: Representative Cobb, LD 5

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HB 2667 allows a dental professional whose license or certification in this state is in good standing to donate dental care and treatment services for indigent and needy persons or persons living in medically underserved areas of this state.

PROVISIONS

1. Includes a dental professional's private office or the patient's place of residence as a nonprofit clinic for purposes related to volunteer care and treatment.
2. Permits a dental professional whose license or certification in this state is in good standing to donate the person's expertise to provide dental care and treatment services for indigent and needy persons or persons living in medically underserved areas of this state pursuant to a written agreement with the Arizona Department of Health Services (ADHS) or ADHS's contractor.
3. Allows ADHS to contract with county health departments or nonprofit clinics with expertise and experience in providing free or charitable dental care and treatment services to indigent and needy persons or persons located in medically underserved areas of this state to administer the services.
4. Requires the agreement between the dental professional and ADHS or their contractor to provide:
   a. That the agreement only applies to volunteer dental care and treatment services delivered by the dental professional to indigent and needy persons or persons located in medically underserved areas of this state.
   b. The identity of the parties to the agreement, including the dental professional's license or certification number.
   c. That the dental professional agrees to not receive any payment or compensation, either direct or indirect, or have the expectation of payment or compensation, for any dental care and treatment services provided to indigent or needy persons or persons located in medically underserved areas of this state under the agreement.
   d. That the dental professional will submit annual reports to ADHS or their contractor regarding the dental care and treatment services delivered to indigent or needy persons or persons located in medically underserved areas of this state. Under the agreement, ADHS and their contractor must have access to the medical records of any patient served by the dental professional. All patient medical records and identifying information contained in the annual reports submitted to ADHS or their contractor are confidential.

e. That ADHS or their contractor may terminate the agreement with the dental professional for appropriate cause. When terminating an agreement under this section, ADHS or their contractor must provide the dental professional with written notice of intent to terminate the agreement and the reasons for the termination at least five business days before the termination date. If the termination date is during the treatment of a patient, the termination date must be moved to the date the treatment of the patient is completed.
f. That the dental professional is subject to regular supervision and inspection by ADHS or their contractor with respect to dental care and treatment services provided under the agreement.

5. Requires the dental professional to report any adverse incident and information relating to treatment outcomes pertaining to a patient to ADHS or their contractor and to the State Board of Dental Examiners (Board). The Board must review the incident and determine whether it involved conduct by the dental professional that is subject to disciplinary action.
6. States that all patient medical records and identifying information contained in adverse incident reports and treatment outcomes obtained by ADHS, their contractor or the Board are confidential.
7. Prohibits a dental professional from submitting a claim for uncompensated care for volunteer dental care and treatment services.
8. Defines *adverse incident, dental professional* and *medically underserved area.*

CURRENT LAW

A.R.S § 12-571 states that a health professional who provides medical, optometric or dental treatment, care or screening within the scope of the health professional's certificate or license at a nonprofit clinic where neither the professional nor the nonprofit clinic receives compensation for any treatment, care or screening provided at the nonprofit clinic is not liable in a medical malpractice action, unless the health professional was grossly negligent. A health professional who provides previously owned prescription eyeglasses free of charge within the professional's scope of practice through a charitable, nonprofit or fraternal organization is not liable for an injury to the recipient if the recipient or the recipient's parent or legal guardian has signed a medical malpractice release form and the injury is not a direct result of the health professional's intentional misconduct or gross negligence. Statute also defines *nonprofit clinic* and *medical malpractice release form.*

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HB 2667

DATE February 16, 2016 MOTION: dp

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 25

HOUSE OF REPRESENTATIVES

HCR 2039

multiple sclerosis awareness week

Prime Sponsor: Representative Brophy McGee, et al., LD 28

X Committee on Health

Caucus and COW

House Engrossed

OVERVIEW

HCR 2039 urges members of the Legislature, to recognize and support individuals and their families who have been impacted by Multiple Sclerosis (MS), to proclaim March 7 through March 13, 2016 as MS awareness week in Arizona.

PROVISIONS

1. Urges the members of the Legislature to:
   a. Recognize the individuals and their families who have been impacted by MS to acknowledge they are great assets to this state;
   b. Support the men, women and families of all people who have been diagnosed with MS and other neurological diseases;
   c. Recognize the importance of finding the cause of and cure for MS and express their appreciation for the dedication that the Arizona Chapter of the National MS Society and its members have shown toward a MS free future; and
   d. Proclaim March 7 through March 13, 2016 as MS awareness week in Arizona and encourage all citizens to learn more about MS and what they can do to support individuals with the disease and their families.

ADDITIONAL INFORMATION

MS is a chronic and often devastating neurological disease of the central nervous system that affects at least 2.3 million people worldwide. MS generally strikes people between the ages of 20 and 50 and causes unpredictable effects. In addition, the progression, severity and specific symptoms of each case cannot be foreseen. The cause and cure for this often debilitating disease remains unknown.

The Arizona Chapter of the National MS Society reports that Arizona serves more than 8,000 individuals in this state who have been diagnosed with MS, affecting 40,000 family members. For over 65 years the Arizona Chapter of the National MS Society has been heightening public knowledge about the disease while mobilizing people and resources. Since 1946, the National MS Society has been relentlessly pursuing prevention, treatment and a cure and has invested more than $920 million dollars in groundbreaking research. Monies raised through the National MS Society, totaling nearly $54 million dollars annually, fuel the efforts of more than 380 research projects globally at the best medical centers and universities and at other institutions throughout the Unites States and abroad.

ARIZONA HOUSE OF REPRESENTATIVES
Fifty-second Legislature - Second Regular Session

ROLL CALL VOTE

COMMITTEE ON HEALTH BILL NO. HCR 2039

DATE February 16, 2016 MOTION: dp

	PASS	AYE	NAY	PRESENT	ABSENT
Mr. Boyer		✓			
Mr. Friese		✓			
Mr. Lawrence		✓			
Mr. Meyer		✓			
Mrs. Cobb, Vice-Chairman		✓			
Mrs. Carter, Chairman		✓			
		6	0	0	0

Sandy Kelley
COMMITTEE SECRETARY

APPROVED:

HEATHER CARTER, Chairman
REGINA COBB, Vice-Chairman

ATTACHMENT

Attachment 27

ARIZONA STATE LEGISLATURE

Fifty-second Legislature - Second Regular Session

COMMITTEE ATTENDANCE RECORD

COMMITTEE ON **HEALTH**

CHAIRMAN: Heather Carter VICE-CHAIRMAN: Regina Cobb

	DATE	2/16 /16	/16	/16	/16	/16
	CONVENED	4:33 m	m	m	m	m
	RECESSED					
	RECONVENED					
	ADJOURNED	8:50 pm				
MEMBERS						
Mr. Boyer		✓				
Mr. Friese		✓				
Mr. Lawrence		✓				
Mr. Meyer		✓				
Mrs. Cobb, Vice-Chairman		✓				
Mrs. Carter, Chairman		✓				

√ Present --- Absent exc Excused

Attachment 28